Illinois Department of Insurance

Standard Health Employee Application for Small Employers

Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001
1-866-445-5364 (toll -free)
TDD 217/524-4872
http://insurance.illinois.gov

Updated - 08/01/2017

INSURER USE ONLY	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.
Policy/Group Number	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.
Section Number	
Effective Date	
New Hire Waiting Period	

TO BE COMPLETED BY EMPLOYER

Employer Name	**Phone #**

Address	**City**	**State**	**Zip**

The information provided in this application will be sent to the following insurance companies:

Insurer	**Insurer**
Insurer	**Insurer**
Insurer	**Insurer**

Reason for Enrollment (Mark all that apply)

New Enrollment ☐ **New Group** ☐ **Open Enrollment** ☐ **Late Enrollee** ☐ **New Hire** ☐

If New Hire, please provide hire date

Special Enrollment Reason

Date of Event _____ **Marriage** ☐ **Divorce** ☐ **Dependent Addition** ☐ **Adoption** ☐

Domestic Partner ☐ **Newborn** ☐ **Loss of Coverage** ☐ **Court Order** ☐ **Other (please explain)**

Employment Status

Employee ☐ **Dependent** ☐	**Active** ☐ **Retiree** ☐ **Retirement Date**
Illinois Continuation ☐ **COBRA** ☐	**Qualifying Event**
Start Date	**Projected End Date**

A Employee Information

Employee Name	Last	First	MI

Job Title	Hire Date	Hrs/Week

Marital Status Married ☐ Single ☐ Divorce ☐ Widowed ☐ Domestic Partner ☐

Address	City	State	Zip

Phone	Email (optional)

B Coverage Requested

Medical

Employee	Yes ☐ No ☐	Spouse/Domestic Partner	Yes ☐ No ☐	Child(ren)	Yes ☐ No ☐

☐ **No Plan Choice** (If you are waiving (declining) coverage for yourself or any member of your family, you **MUST** complete Section C below.)

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 also 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 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(s) 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 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 hereby waive, coverage for (check all that apply)

	Myself	Spouse/Domestic Partner	Dependent Child(ren)	Not Offered
Medical	☐	☐	☐	☐
Dental	☐	☐	☐	☐
Vision	☐	☐	☐	☐
Basic Life	☐	☐	☐	☐
Dependent Life	☐	☐	☐	☐
Voluntary Life	☐	☐	☐	☐
Short-Term Disability	☐	☐	☐	☐
Long-Term Disability	☐	☐	☐	☐

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 Section H of this application.*****

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 of Insurance website at http://insurance.illinois.gov.
<u>Note**</u>: 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**	**Gender**	
HMO only (if applicable)	**Primary Care Physician Name**	**Physician ID**	
Spouse/Domestic Partner Name	**Last**	**First**	**MI**
Social Security Number	**Date of Birth**	**Gender**	
HMO only (if applicable)	**Primary Care Physician Name**	**Physician ID**	
Dependent Name	**Last**	**First**	**MI**
Social Security Number	**Date of Birth**	**Gender**	
HMO only - Primary Care Physician Name & ID	**Eligible Military Veteran**	**Yes** ☐	**No** ☐
Dependent Name	**Last**	**First**	**MI**
Social Security Number	**Date of Birth**	**Gender**	
HMO only - Primary Care Physician Name & ID	**Eligible Military Veteran**	**Yes** ☐	**No** ☐
Dependent Name	**Last**	**First**	**MI**
Social Security Number	**Date of Birth**	**Gender**	
HMO only - Primary Care Physician Name & ID	**Eligible Military Veteran**	**Yes** ☐	**No** ☐
Dependent Name	**Last**	**First**	**MI**
Social Security Number	**Date of Birth**	**Gender**	
HMO only - Primary Care Physician Name & ID	**Eligible Military Veteran**	**Yes** ☐	**No** ☐

E Current/Prior Coverage Information

Please indicate for **EACH person listed on this application any health coverage, including Medicare or Medicaid, in effect within 24 months prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health care coverage was in effect within the past 24 months, please indicate **NONE**.

**If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation showing who is responsible for the dependent(s)' health care coverage so that the insurer can determine whose coverage is primary.

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

Employee Name | Last | First | MI

Current/Most Recent Coverage Group Medical ☐ Individual Medical ☐ Dental ☐ None ☐

Dates of Coverage From To | Will this coverage continue? Yes ☐ No ☐

Policyholder Name | Insurer Name

Prior Coverage (if any) Group Medical ☐ Individual Medical ☐ Dental ☐ None ☐

Dates of Coverage From To

Policyholder Name | Insurer Name

Spouse/Domestic Partner Name | Last | First | MI

Current/Most Recent Coverage Group Medical ☐ Individual Medical ☐ Dental ☐ None ☐

Dates of Coverage From To | Will this coverage continue? Yes ☐ No ☐

Policyholder Name | Insurer Name

Prior Coverage (if any) Group Medical ☐ Individual Medical ☐ Dental ☐ None ☐

Dates of Coverage From To

Policyholder Name | Insurer Name

Dependent Name | Last | First | MI

Current/Most Recent Coverage Group Medical ☐ Individual Medical ☐ Dental ☐ None ☐

Dates of Coverage From To | Will this coverage continue? Yes ☐ No ☐

Policyholder Name | Insurer Name

Prior Coverage (if any) Group Medical ☐ Individual Medical ☐ Dental ☐ None ☐

Dates of Coverage From To

Policyholder Name | Insurer Name

E	Current/Prior Coverage Information - ***CONTINUED***							
Dependent Name	**Last**		**First**			**MI**		
Current/Most Recent Coverage	**Group Medical** ☐		**Individual Medical** ☐		**Dental** ☐	**None** ☐		
Dates of Coverage	**From**		**To**		**Will this coverage continue?**	**Yes** ☐	**No** ☐	
Policyholder Name			**Insurer Name**					
Prior Coverage (if any)	**Group Medical** ☐		**Individual Medical** ☐	**Dental** ☐	**None** ☐			
Dates of Coverage	**From**		**To**					
Policyholder Name			**Insurer Name**					
Dependent Name	**Last**		**First**			**MI**		
Current/Most Recent Coverage	**Group Medical** ☐		**Individual Medical** ☐		**Dental** ☐	**None** ☐		
Dates of Coverage	**From**		**To**		**Will this coverage continue?**	**Yes** ☐	**No** ☐	
Policyholder Name			**Insurer Name**					
Prior Coverage (if any)	**Group Medical** ☐		**Individual Medical** ☐	**Dental** ☐	**None** ☐			
Dates of Coverage	**From**		**To**					
Policyholder Name			**Insurer Name**					
Dependent Name	**Last**		**First**			**MI**		
Current/Most Recent Coverage	**Group Medical** ☐		**Individual Medical** ☐		**Dental** ☐	**None** ☐		
Dates of Coverage	**From**		**To**		**Will this coverage continue?**	**Yes** ☐	**No** ☐	
Policyholder Name			**Insurer Name**					
Prior Coverage (if any)	**Group Medical** ☐		**Individual Medical** ☐	**Dental** ☐	**None** ☐			
Dates of Coverage	**From**		**To**					
Policyholder Name			**Insurer Name**					

F Medicare

If you or any family members listed on this application have Medicare coverage, please complete the following information.

Enrolling Individual Name	Last	First	MI

Medicare Number (please include alpha prefix)	Medicare Part(s) A ☐ B ☐ D ☐	Effective Date

Reason for Medicare Entitlement Age ☐ Disability ☐ ESRD ☐ Dual Enrollment ☐

Enrolling Individual Name	Last	First	MI

Medicare Number (please include alpha prefix)	Medicare Part(s) A ☐ B ☐ D ☐	Effective Date

Reason for Medicare Entitlement Age ☐ Disability ☐ ESRD ☐ Dual Enrollment ☐

G Additional Coverage Options

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

Employee

Dental ☐ PPO ☐ HMO ☐ Vision ☐ Dental HMO Office ID # (if applicable)

Basic Life ☐ Dependent Life ☐ Voluntary Life ☐ Amount (if applicable) $

Short Term Disability ☐ Long Term Disability ☐ Employee Class (employer will provide if needed)

Salary (if requesting life or disability coverage) $ Hourly ☐ Weekly ☐ Monthly ☐ Semi-Monthly ☐ Annually ☐

Spouse/Domestic Partner

Dental ☐ PPO ☐ HMO ☐ Vision ☐ Dental HMO Office ID # (if applicable)

Basic Life ☐ Dependent Life ☐ Voluntary Life ☐ Amount (if applicable) $

Short Term Disability ☐ Long Term Disability ☐

Child(ren)

Dental ☐ PPO ☐ HMO ☐ Vision ☐ Dental HMO Office ID # (if applicable)

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 %

H	Acknowledgement & Signature
	I understand, agree, and represent that (<u>please initial each line</u>):

____ 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 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.

____ 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.

____ The medical information provided also includes my spouse/domestic partner and/or dependents' information.

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

____ 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 Office of Consumer Health Insurance a Department of Insurance, toll free at (877) 527-9431.