Blue Cross and Blue Shield of Illinois (BCBSIL) Individual Coverage Plan Selection

BlueCross BlueShield of Illinois

HOME OFFICE USE ONLY

To help us process your application promptly, please remember:

- **You must complete and submit the Illinois Standard Health Application for Individual and Family Coverage in addition to this Individual Coverage Plan Selection form to apply for a BCBSIL insurance plan.**
- Please print clearly in **blue or black ink**. Pencil will not be accepted.
- In addition to having a permanent residence in Illinois, all persons applying for coverage who are not U.S. citizens must have resided in the U.S. for at least six months ***AND*** have had a complete physical by a physician in the U.S. within the past two years.
- BCBSIL individual insurance plans do not cover domestic partners.

SECTION A — PRIMARY APPLICANT INFORMATION (please print)

First Name	Middle Initial	Last Name	Date of Birth	Gender ☐ M ☐ F

Residential Street Address *(no P.O. Boxes)*	City / State / ZIP

County	Primary Phone # ☐ Home ☐ Cell ☐ Business ( )

E-mail

CHECK ONE of the following boxes: ☐ New Business ☐ Plan Upgrade ☐ Add Spouse or Child(ren)

SECTION B — PLAN SELECTION: (please choose only one health plan with one deductible and one level of coverage)

☐ **SelectBlue®**
Deductible: ☐ $0 ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 100% ☐ 80%

☐ **SelectBlue Advantage℠**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,750 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 80%

☐ **BlueChoice℠ Select**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,750 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 80%

☐ **BlueValue℠**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 100% ☐ 80%

☐ **BlueValue Advantage℠**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,750 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 80%

☐ **BlueChoice℠ Value**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,750 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 80%

☐ **BlueEdge℠ Individual HSA**
Deductible:
☐ $1,200 for a single applicant or $2,400 for a family*
☐ $1,750 for a single applicant or $3,500 for a family
☐ $2,600 for a single applicant or $5,200 for a family
☐ $3,500 for a single applicant or $7,000 for a family
Level of Coverage: ☐ 100% ☐ 80%

** The deductible amount will be adjusted automatically if the amount is lower than the amount required by law.*

☐ **BlueEdge℠ Individual HSA 5000**
Deductible: $5,000 for a single applicant or $10,000 for a family
Level of Coverage: ☐ 100%

OPTIONAL COVERAGE:

☐ **Include Maternity Coverage?**
You MUST choose a health plan in order to apply for maternity coverage.

☐ **BlueCare® Dental PPO**
You MUST choose a health plan in order to apply for dental.

SECTION C — CURRENT OR PREVIOUS BCBS COVERAGE

Does any person applying for coverage currently have, or did they previously have **within the last 5 years**, Blue Cross and Blue Shield coverage, either as a primary insured, spouse or as a dependent? ☐ **Yes** ☐ **No** ***If "yes", please complete the following:***

Applicant Name	Name on Previous Policy *(if applicable)*	Member/Group# *(optional)*	State

Applicant Name:	Name on Previous Policy *(if applicable)*	Member/Group# *(optional)*	State

SECTION D — BILLING INFORMATION

Note: Do not cancel any current coverage you may have until your new policy is approved and in force.

PREMIUM AMOUNT ENCLOSED: $_____

PAYMENT OPTION (Select One): ☐ **A**. Monthly Bank Draft ☐ **B**. Two-Month Direct Bill

☐ **C**. List Bill (submit a "Personal Health Insurance Certificate for Employees" form with the application) *See Name of Employer box below.*

Option A Information Required: Name of Bank, City and State where account is authorized _____

_____

Please check one: ☐ Checking Account ☐ Savings Account

Bank Transit Number:_____

Depositor's Account Number: _____

Depositor's Signature:_____ Date _____

Options B & C Information Required: Billing Name and Address (If different than applicant name and residential address. If an address is entered in this section, only the billing will be sent to this address; all other correspondence will be sent to the address in Section A, unless you request otherwise.) Name of Employer is required if Option C is chosen.

First Name, Middle Initial, Last Name	
Billing Street Address *(P.O. Boxes acceptable)*	City / State / ZIP
Name of Employer *(if requesting Payment Option C. List Bill only)*	

SECTION E — PROXY INFORMATION

PROXY The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members, or by attending and voting in person at any annual or special meeting of members.

Primary Applicant Signature *(optional)*: X _____

Print Your Name as You Signed It: _____ **Date Signed:** _____ / _____/ _____
Mo./Day/Yr.

SECTION F — REQUIRED SIGNATURES (AGENT, IF APPLICABLE)

I certify that I have received the required Outline of Coverage.

Primary Applicant Signature: X _____ **Date Signed:** _____ / _____/ _____
Mo./Day/Yr.

Agent Signature: X _____ **Date Signed:** _____ / _____/ _____
Mo./Day/Yr.

Print Agent Name: _____ **Agent Code:** _____

Agent Phone Number: ( ) _____ **Agent Fax Number:** ( ) _____

Agent Email Address:_____

Mail Policy(ies) to: ☐ **Agent** ☐ **Applicant**

We must also receive your application within 60 days of the earliest date signed, so please return promptly. Applications received after 60 days will require a new application.

Coverage for preexisting medical conditions may be excluded or be subject to a waiting period of up to 24 months including for dependents under age 19 being added to a policy that was in effect prior to 3/23/10.

QUESTIONS?

1. Call our Customer Service Department toll-free at **1-800-654-7385**
2. Call your insurance agent
3. Visit **bcbsil.com**

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Illinois Standard Health Application for Individual & Family Health Insurance Coverage

For assistance in completing this application, please contact your insurance agent or the insurance company directly. 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.

INSTRUCTIONS:

1. Any information you provide in this application is confidential.
2. The answers you provide in this application must be true and complete, to the best of your knowledge and belief. Do not leave any question unmarked.
3. An intentional misrepresentation may result in your policy being modified or terminated, or in claims being reduced or denied.
4. For purposes of this application, the term "dependent" refers to any child up to age 26 (or age 30 for military veterans) for whom you are requesting coverage, regardless of whether the child may be considered a dependent for tax or other purposes. For information about Illinois' Young Adult Dependent Coverage law, which allows parents to cover children up to age 26, and up to age 30 for military veterans, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

A Primary Applicant Information

Name (Last)	(First)	(MI)
Residential Street Address:		Apt #:
City:	State:	Zip:
Mailing Address (if different):		Apt #:
City:	State:	Zip:
Primary Phone Number: ( )	Best time to call: ☐ Morning ☐ Afternoon ☐ Evening	
Secondary Phone Number: ( )	Best time to call: ☐ Morning ☐ Afternoon ☐ Evening	
Email Address (optional):		
Please check one of the following boxes: ☐ New Application ☐ Dependent Addition ☐ Plan Change ☐ Reinstatement		
Requested Effective Date: _____ (Coverage not in force until the insurance carrier approves your application and determines the effective date.)		

B Employment Information

Occupation:	Job Title:
Spouse/Domestic Partner's Occupation:	Job Title:
Currently employed? (optional) Self: ☐ Yes ☐ No Spouse/Domestic Partner: ☐ Yes ☐ No	

PRIMARY APPLICANT NAME ______________________________ DATE ____________________

C Persons Requesting Coverage

List all family members you wish to include under the policy. Insurance companies may have different rules about who may qualify as an eligible dependent. For more information regarding the available coverage, please check with your insurance agent or insurance carrier.

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.

Self Name (Last) ____________________ (First) ____________________ (MI) ______

Social Security Number (for internal use only):

Date of Birth: / /

State of Birth (country if born outside the U.S.):

Gender: ☐ Male ☐ Female

Percentage of time annually spent outside of Illinois for residence, work, or school:

Spouse/Domestic Partner Name (Last) ____________________ (First) ____________________ (MI) ______

Social Security Number (for internal use only):

Date of Birth: / /

State of Birth (country if born outside the U.S.):

Gender: ☐ Male ☐ Female

Percentage of time annually spent outside of Illinois for residence, work, or school:

Dependent Name (Last) ____________________ (First) ____________________ (MI) ______

Relationship to Applicant:

Date of Birth: / /

Social Security Number (for internal use only):

Gender: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ No

Percentage of time annually spent outside of Illinois for residence, work, or school:

Dependent Name (Last) ____________________ (First) ____________________ (MI) ______

Relationship to Applicant:

Date of Birth: / /

Social Security Number (for internal use only):

Gender: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ No

Percentage of time annually spent outside of Illinois for residence, work, or school:

Dependent Name (Last) ____________________ (First) ____________________ (MI) ______

Relationship to Applicant:

Date of Birth: / /

Social Security Number (for internal use only):

Gender: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ No

Percentage of time annually spent outside of Illinois for residence, work, or school:

PRIMARY APPLICANT NAME _____ DATE _____

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

Relationship to Applicant: | Date of Birth: / /

Social Security Number (for internal use only): | Gender: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ No

Percentage of time annually spent outside of Illinois for residence, work, or school:

D Current/Prior Coverage Information

For EACH person listed on this application, please indicate any public health insurance coverage (for example, Medicare, HFS Medical Card, All Kids, Family Care, or other federal and state programs) or private health insurance in effect within the **last 12 months**. Each person applying for insurance must be listed below. If health insurance coverage was not in effect within the **last 12 months**, please indicate **NONE.**

Self Name (Last) _____ (First) _____ (MI) _____

▶ **Current/Most Recent Coverage**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____
▶ Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

▶ **Prior Coverage (if any):**
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____ _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

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

▶ **Current/Most Recent Coverage**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____
▶ Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

▶ **Prior Coverage (if any):**
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____ _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

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

▶ **Current/Most Recent Coverage**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____
▶ Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

▶ **Prior Coverage (if any):**
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____ _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

PRIMARY APPLICANT NAME ________________________________ DATE ____________________

Dependent Name (Last) ______________________ (First) ______________________ (MI) ______

▶ **Current/Most Recent Coverage**:

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ________________________________)

▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

▶ Is the issuance of this coverage **replacing** your existing coverage?✶ ☐ Yes ☐ No

▶ **Prior Coverage (if any)**:

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ____________ ____________________)

▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

Dependent Name (Last) ______________________ (First) ______________________ (MI) ______

▶ **Current/Most Recent Coverage**:

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ________________________________)

▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

▶ Is the issuance of this coverage **replacing** your existing coverage?✶ ☐ Yes ☐ No

▶ **Prior Coverage (if any)**:

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ____________ ____________________)

▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

Dependent Name (Last) ______________________ (First) ______________________ (MI) ______

▶ **Current/Most Recent Coverage**:

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ________________________________)

▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

▶ Is the issuance of this coverage **replacing** your existing coverage?✶ ☐ Yes ☐ No

▶ **Prior Coverage (if any)**:

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ____________ ____________________)

▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

✶ If answering "YES" please carefully read the following notice.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT & HEALTH INSURANCE

According to information you have furnished, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by the insurance carrier. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the insurance carrier to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.
4. It is recommended that you do not terminate your present contract until you are certain that your application for the new contract has been approved by the insurance carrier.

PRIMARY APPLICANT NAME _____ DATE _____

DEPENDENT NAME (If submitted separately) _____

E Health Statement

The federal **Genetic Information Nondiscrimination Act** prohibits health insurers from asking for and using **"genetic information"** when deciding whether to offer coverage and how much to charge for coverage. For more information on the Genetic Information Nondiscrimination Act, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

Instructions:

1. Each medical question below applies to each person requesting coverage.
2. Answer the questions below by checking Yes or No. If you answer Yes to any question, you must provide additional information in Section F below.
3. Do not leave any question unmarked.

Limited Privacy Available: Persons age 18 or older may submit a signed and dated separate health statement. The information provided in such separate health statement(s) will likely be disclosed to the primary applicant.

1 For any of the following conditions, **within the past FIVE (5) years**, has anyone applying for coverage:

- Been diagnosed with;
- Had treatment or testing recommended;
- Received treatment, including prescription medications; or
- Been hospitalized for any illness, injury, or health condition listed below?

If answering "YES," check all that apply.

A. **Heart/Circulatory Conditions/Disorders:** ☐ Yes ☐ No

▶ **Heart:** ☐ Heart attack ☐ Chest pain ☐ Heart murmur ☐ Irregular heartbeat
☐ High/elevated blood pressure* ☐ High/elevated cholesterol*
✶ If applicable, please provide last known blood pressure or cholesterol reading in Section F.

▶ **Circulatory:** ☐ Anemia ☐ Bleeding/clotting disorder ☐ Varicose/spider veins ☐ Phlebitis

B. **Lymphatic Conditions/Disorders:** ☐ Yes ☐ No

☐ Lymphadenopathy ☐ Enlarged lymph nodes ☐ Disease of the spleen

C. **Cancer/Tumors/Growths:** ☐ Yes ☐ No

☐ Cancer ☐ Tumors ☐ Cysts ☐ Polyps ☐ Lumps ☐ Other abnormal growths

D. **Respiratory Conditions/Disorders:** ☐ Yes ☐ No

☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Sleep apnea ☐ Pneumonia ☐ Tuberculosis
☐ Chronic obstructive pulmonary disease (COPD)

E. **Intestinal/Digestive Conditions/Disorders:** ☐ Yes ☐ No

☐ Acid reflux ☐ Ulcers ☐ Hernia *(indicate type)* ☐ Colitis ☐ Hemorrhoids ☐ Rectal bleeding ☐ Gallstones
☐ Irritable bowel syndrome ☐ Chronic diarrhea ☐ Hepatitis *(indicate type)* ☐ Elevated liver function test
☐ Jaundice ☐ Cirrhosis ☐ Gallbladder infection or inflammation ☐ Pancreatitis ☐ Crohn's disease

F. **Urinary Conditions/Disorders:** ☐ Yes ☐ No

☐ Kidney infection ☐ Kidney stones ☐ Bladder infection ☐ Cystitis ☐ Urinary reflux ☐ Urinary tract infection

G. **Metabolic/Endocrine Conditions/Disorders:** ☐ Yes ☐ No

☐ Diabetes ☐ Thyroid disorder ☐ High/low blood sugar ☐ Adrenal, pituitary, or other glandular disorder
☐ Chronic fatigue syndrome ☐ Obesity/weight loss surgery

PRIMARY APPLICANT NAME _____ DATE _____

DEPENDENT NAME (If submitted separately) _____

H. **Brain/Nervous System Conditions/Disorders:** ☐ Yes ☐ No

☐ Seizures ☐ Migraine headaches/Chronic severe headaches ☐ Head injury ☐ Paralysis ☐ Epilepsy ☐ Tremor
☐ Stroke or TIA ☐ Multiple sclerosis ☐ Parkinson's ☐ Restless leg syndrome ☐ Lou Gehrig's disease (ALS)

I. **Immune System Conditions/Disorders:** ☐ Yes ☐ No

☐ HIV positive ☐ AIDS ☐ Diseases associated with AIDS

J. **Musculoskeletal Conditions/Disorders:** ☐ Yes ☐ No

☐ Arthritis ☐ Gout ☐ Lupus ☐ Herniated disc ☐ Temporomandibular joint disorder (TMJ)
☐ Carpal tunnel syndrome ☐ Disease/disorder of the back or spine ☐ Other bone or joint disorder

K. **Mental/Behavioral/Emotional Conditions/Disorders:** ☐ Yes ☐ No

☐ Depression ☐ Anxiety disorder ☐ Attention deficit disorder ☐ Chemical imbalance ☐ Bi-polar disorder
☐ Obsessive compulsive disorder ☐ Eating disorder

L. **Allergies:** ☐ Yes ☐ No

☐ Allergies in any form ☐ Hay fever ☐ Hives ☐ Anaphylaxis

M. **Eye Conditions/Disorders:** ☐ Yes ☐ No

☐ Glaucoma ☐ Cataracts ☐ Strabismus (crossed eyes) ☐ Detached retina

N. **Ear Conditions/Disorders:** ☐ Yes ☐ No

☐ Hearing disorder ☐ Ear infection ☐ Loss of hearing

O. **Nasal Conditions/Disorders:** ☐ Yes ☐ No

☐ Deviated septum ☐ Adenoiditis ☐ Sinusitis

P. **Throat Conditions/Disorders:** ☐ Yes ☐ No

☐ Tonsillitis ☐ Strep throat

Q. **Skin Conditions/Disorders:** ☐ Yes ☐ No

☐ Acne ☐ Psoriasis ☐ Eczema ☐ Keratosis ☐ Pre-cancerous lesions ☐ Herpes ☐ Melanoma

R. **Congenital Abnormalities/Developmental Disorders:** ☐ Yes ☐ No

- **Congenital Abnormality:** ☐ Cleft palate/lip ☐ Club foot ☐ Heart/lung/kidney defect or malformation
- **Developmental Disorder:** ☐ Pervasive development disorder ☐ Down's syndrome ☐ Autism spectrum disorder ☐ Learning disability

S. **Reproductive System Conditions/Disorders:** ☐ Yes ☐ No

- **Female:** ☐ Infertility ☐ Abnormal menstrual bleeding ☐ Abnormal PAP smear ☐ Endometriosis ☐ Ovarian cyst ☐ Sexually transmitted disease ☐ Human papillomavirus (HPV) ☐ Pregnancy complications ☐ Uterine fibroid ☐ Breast infection or inflammation
- Is any female applicant currently pregnant, an expectant parent, or in the process of adopting? ☐ Yes ☐ No
- **Male:** ☐ Infertility ☐ Erectile dysfunction ☐ Sexually transmitted disease ☐ Prostate disorder ☐ Gynecomastia
- Is any male applicant an expectant parent or in the process of adopting? ☐ Yes ☐ No

T. **Other Conditions:** ☐ Yes ☐ No

Within the **past 5 years**, has anyone applying for coverage been diagnosed with, had treatment or testing recommended, received treatment, including prescription medications, or been hospitalized for **any illness, injury, or health condition not indicated elsewhere in this application?**

Note: You must include any illness, injury, or health condition related to one of the categories above, even if your specific illness, injury, or condition is not listed above.

PRIMARY APPLICANT NAME _____ DATE _____

DEPENDENT NAME (If submitted separately) _____

Within the past FIVE (5) YEARS:		
2 Has anyone applying for coverage received treatment or had treatment recommended for drug or alcohol abuse, or been convicted of a drug or alcohol related offense (including a DUI)?	☐ Yes	☐ No
3 **Other than indicated elsewhere on this application**, has anyone applying for coverage had an implant (e.g., breast, chin, or penile implant), internal fixation (e.g., pins, plates, rods, screws), prosthesis, pacemaker, heart valve replacement, shunt, or monitoring device?	☐ Yes	☐ No
4 Has anyone applying for coverage had testing performed and are currently **waiting for results**, or been advised to have treatment, testing, counseling, therapy, or surgery which has **not yet been performed**?	☐ Yes	☐ No

Within the past TWELVE (12) MONTHS:		
5 Has anyone applying for coverage experienced unexpected weight gain or loss of more than 20 pounds?	☐ Yes	☐ No
6 Has anyone applying for coverage used any tobacco product (such as cigarettes, snuff, chewing tobacco, or any nicotine substitution product)? ▶ If yes, indicate who: ☐ Primary Applicant ☐ Spouse/Domestic Partner ☐ Dependent Children	☐ Yes	☐ No
7 Has anyone applying for coverage participated in any dangerous or extreme sport activities, including, but not limited to: organized automobile/motorcycle/powerboat racing, skydiving, bungee jumping, ultralight flying, scuba diving, hang gliding, or outdoor rock/mountain climbing?	☐ Yes	☐ No

If yes, indicate:

Who & Which Activity	When/How Often	Do you plan continued participation?
_____		☐ Yes ☐ No
_____		☐ Yes ☐ No
_____		☐ Yes ☐ No

8 **Other than indicated elsewhere on this application**, has any person applying for coverage EVER been treated, hospitalized, or had surgery for:

- bypass? ☐ Yes ☐ No
- angioplasty? ☐ Yes ☐ No
- stent? ☐ Yes ☐ No
- aneurysm? ☐ Yes ☐ No
- valve replacement? ☐ Yes ☐ No
- cancer? ☐ Yes ☐ No
- stroke? ☐ Yes ☐ No
- congenital abnormality? ☐ Yes ☐ No
- organ or bone marrow transplant? ☐ Yes ☐ No

PRIMARY APPLICANT NAME _____ DATE _____

DEPENDENT NAME (If submitted separately) _____

9 For **EACH** person applying for coverage, complete the following information regarding his/her **last physical exam** (including checkups):

Self Name:_____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Spouse/Domestic Partner's Name: _____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:_____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:_____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:_____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:_____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

10 For **EACH** person applying for coverage, provide the following <u>current</u> information regarding his/her **height and weight**:

Self Name:_____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

Spouse/Domestic Partner's Name: _____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

Dependent's Name:_____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

Dependent's Name:_____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

Dependent's Name:_____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

Dependent's Name:_____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

F Additional Information

If you answered "YES" to any of the questions in Section E, you must provide additional information below. For an example of how to fill out this section, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

Attach a separate sheet for additional information if necessary.

Question Number: _____ Name of Individual: _____

Condition/Diagnosis: _____

Treatment Received: _____

_____

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: _____

Additional tests or treatment recommended? _____

Medication Prescribed (if any): _____

_____ Currently taking medication? ☐ Yes ☐ No

Physician Name _____

Phone # (_____)_____ City & State _____

PRIMARY APPLICANT NAME ____________________ DATE ____________

DEPENDENT NAME (If submitted separately) ____________________

Question Number: ______ Name of Individual: ____________________

Condition/Diagnosis: ____________________

Treatment Received: ____________________

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ____________________

Additional tests or treatment recommended? ____________________

Medication Prescribed (if any): ____________________

____________________ Currently taking medication? ☐ Yes ☐ No

Physician Name ____________________

Phone # (________)______________ City & State ____________________

Question Number: ______ Name of Individual: ____________________

Condition/Diagnosis: ____________________

Treatment Received: ____________________

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ____________________

Additional tests or treatment recommended? ____________________

Medication Prescribed (if any): ____________________

____________________ Currently taking medication? ☐ Yes ☐ No

Physician Name ____________________

Phone # (________)______________ City & State ____________________

Question Number: ______ Name of Individual: ____________________

Condition/Diagnosis: ____________________

Treatment Received: ____________________

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ____________________

Additional tests or treatment recommended? ____________________

Medication Prescribed (if any): ____________________

____________________ Currently taking medication? ☐ Yes ☐ No

Physician Name ____________________

Phone # (________)______________ City & State ____________________

Question Number: ______ Name of Individual: ____________________

Condition/Diagnosis: ____________________

Treatment Received: ____________________

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ____________________

Additional tests or treatment recommended? ____________________

Medication Prescribed (if any): ____________________

____________________ Currently taking medication? ☐ Yes ☐ No

Physician Name ____________________

Phone # (________)______________ City & State ____________________

PRIMARY APPLICANT NAME ______________________ DATE ______________

DEPENDENT NAME (If submitted separately) ____________________________

G Prescription Information within the Last Twelve (12) Months

Within the past 12 months, has anyone applying for coverage been prescribed medication (other than for the common cold or flu) that is **not indicated elsewhere in this application**? ☐ Yes ☐ No

Attach a separate sheet for additional information if necessary.

Name of Individual: ______________________

Name of Medication: ______________________

Reason for Taking: ______________________

First & Last Treatment Date: ______________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ______________________

Phone # (______)______________ City & State ______________

Name of Individual: ______________________

Name of Medication: ______________________

Reason for Taking: ______________________

First & Last Treatment Date: ______________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ______________________

Phone # (______)______________ City & State ______________

Name of Individual: ______________________

Name of Medication: ______________________

Reason for Taking: ______________________

First & Last Treatment Date: ______________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ______________________

Phone # (______)______________ City & State ______________

Name of Individual: ______________________

Name of Medication: ______________________

Reason for Taking: ______________________

First & Last Treatment Date: ______________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ______________________

Phone # (______)______________ City & State ______________

Name of Individual: ______________________

Name of Medication: ______________________

Reason for Taking: ______________________

First & Last Treatment Date: ______________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ______________________

Phone # (______)______________ City & State ______________

PRIMARY APPLICANT NAME _____ DATE _____

AFFIRMATION

Signature – Adult applicants must sign this form below. Parent or guardian signature is required for applicants under the age of 18. **By signing this form, you certify the following**:

1. I have read this entire application or it has been read to me.
2. No independent producer, agent, or employee of the insurer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
3. 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.
4. **All of the answers provided within this application are, to the best of my knowledge and belief, true and complete.** For more information, please visit the Illinois Department of Insurance's website at www.insurance.illinois.gov.

STATEMENT OF UNDERSTANDING

I understand and agree that:

- The information I have provided in this application will be used by the insurer to determine whether to extend coverage and the premium amount for such coverage.
- No coverage shall be in force until approved by the insurer. If approved, coverage will be in force as of the effective date determined by the insurer.
- This application will become part of the contract between the insurer and me.
- Except for a dependent up to the age of 19, coverage for preexisting medical conditions may be excluded or be subject to a waiting period of up to 24 months.
- I am entitled to a copy of this application and the Authorization to Use and Disclose Protected Health Information that is a part of this application upon request. I agree that a photographic copy shall be as valid as the original. A legible facsimile signature shall have the same force and effect as the original.
- I authorize the insurer to transmit the information contained herein electronically.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I. Protected Health Information

By signing this form, I authorize certain organizations and persons to use or disclose my protected health information. Protected health information includes, but is not limited to, hospital records, physician records, claim or benefit records, lab results, mental health records, as well as information regarding the use of drug, alcohol, HIV/AIDS, sexually transmitted disease, and reproductive health services. Protected health information may be written, oral, or electronic. This form does not permit the use or disclosure of psychotherapy notes.

II. Purpose of this Authorization Form

By signing this form, I authorize the use and disclosure of protected health information for the purposes of pre-enrollment underwriting or risk-rating of health insurance coverage, to determine eligibility for enrollment or benefits under a health plan, or to allow the insurer to conduct utilization review and quality improvement activities ("Purpose").

III. Entities Authorized to Use and Disclose My Protected Health Information

Insurers: I hereby authorize the following insurers, their reinsurers, and their legal representatives ("Insurers") to receive, use, and disclose my protected health information for the Purpose listed above:

(Please list below the names of all the insurers to whom you are submitting this application).

Insurer: _____ Insurer: _____ Insurer: _____

Insurer: _____ Insurer: _____ Insurer: _____

PRIMARY APPLICANT NAME _____ DATE _____

I authorize the Insurers to disclose my protected health information: between themselves, to reinsuring companies, and to insurance intermediaries or other persons or organizations performing business or legal services in connection with the Purpose above.

I further authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, or other organization, institution, or person that has any record or knowledge of my health to disclose such information to the extent permitted by law to Insurers for the Purpose above.

I understand that protected health information described in this form may be used by, or disclosed to or by, organizations and persons who are not subject to federal or state privacy laws.

IV. Term of Authorization

I agree this Authorization shall be valid for two-and-one-half (2 ½) years from the latest signature date below.

V. Right to Revoke

I understand I may revoke this authorization at any time by giving advance written notice to Insurers. Revocation of this authorization form will not affect actions Insurers and others took in reliance on this form prior to the written notice of revocation.

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.

I HAVE READ AND CONSIDERED THE CONTENTS OF THIS FORM. BY SIGNING THIS FORM, I HEREBY AUTHORIZE THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

_____Date _____
Primary Applicant (or Authorized Legal Representative) Signature

_____Date _____
Spouse / Domestic Partner Signature (ONLY if to be insured)

_____Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

_____Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

_____Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

_____Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

✪ For assistance in completing this application, please contact your insurance agent or the insurance company directly. 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.

PRIMARY APPLICANT NAME _____ DATE _____

TO BE COMPLETED BY AGENT
I. Agent/Producer Information

I certify that:
1. All answers provided in this application were completed by or provided by the applicant.
2. I have reviewed this enrollment form to ensure that all required items have been completed.
3. I am not aware of any information not disclosed on this enrollment form relating to the health, habits, or reputation of any person listed on this enrollment form, which might have a bearing on the risk.

1. Producer/Writing Agent

Name:	ID#/Code:
Company:	Phone: ( )
Email:	
Producer Signature: Date Signed: (A faxed signature shall be valid as an original signature.)	

2. Agent/Managing Agent

Name:	ID#/Code:
Company:	Phone: ( )
Email:	
Agent Signature: Date Signed: (A faxed signature shall be valid as an original signature.)	