ASSURANT
Health®

TIP SHEET

Illinois Standard Health Application for Individual & Family Health Insurance Coverage Packet For Individual Medical Underwriting

Step 1: Complete the application and forms

This packet includes the necessary forms you'll need to submit your application with us.

- Illinois Standard Health Application for Individual & Family Health Insurance Coverage
- Billing Selection Form
- Health Advocates Alliance Membership Application Form
- Employer Sponsored Business Questionnaire
- Illinois Individual Health Insurance Underwriting Authorization *(all applicants age 18 and over must sign)*
- The last page of the packet (Illinois Individual Health Insurance Additional Notices) should stay with the applicant and not be submitted to us. Any dependent age 18 or over should have an opportunity to review this page of the packet.
- All forms must include signatures in pen (not typed)
- Other forms may be necessary that are not part of this packet (i.e. Preferred Questionnaire), these forms can be found on assuranthealthsales.com

Limited Privacy Available: Dependents age 18 or over have a right to Limited Privacy. They may submit their health history via a separate health statement. The information provided in the separate health statement(s) will likely be disclosed to the primary applicant.

If a dependent(s) age 18 or over wishes to submit a separate health statement, he or she should complete the following steps:

1.) include that member of the family in Section C, Persons Requesting Coverage, of the primary insured's application.

2.) after the dependent's name, indicate that he or she is submitting a separate Health Statement.

3.) make sufficient copies of pages 5-12 of the application for each dependent applicant to complete, if they wish to submit their information separately.

4.) the dependent(s) should then complete his or her own copy of pages 5-12, Sections E-G, the AFFIRMATION, STATEMENT OF UNDERSTANDING AND AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION sections, of the health statement. Each dependent should also list his or her name in the "Dependent Name (if submitted separately)" section at the top of pages 5-10 of the separate health statement.

5.) the dependent(s) must also sign page 12 of the separate health statement.

6.) DO NOT FAX either the primary insured's or the dependent's separate health statement.

7.) to preserve maximum confidentiality, the dependent's Health Statement may be placed in a separate smaller envelope to be included in the mailing with the application for the primary applicant and any remaining family members.

(continued)

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Step 2: Submit the application

- If all family member information is included on one application, submit the fully completed labeled application and forms via fax 414-299-6020 or mailing address: Assurant Health, PO Box 624, Milwaukee WI, 53201. *Note: Applications must be received by us within 30 days of the signature date*
- Families wishing to submit more than one Section E-G, the AFFIRMATION, STATEMENT OF UNDERSTANDING AND AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION sections, Health Statement should submit all the separate health statements with the original application and send them to the PO Box in the same main envelope.
Do NOT fax the applications.
- *Include the quote*

Thank you for your business. We will keep you updated of your submission through EASE.

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Assurant Health
501 W. Michigan Ave.
Milwaukee, WI 53203

Important Notice Regarding Dependent Coverage for Insurance in the State of Illinois

On June 1, 2009, an Illinois Division of Insurance law took effect. The law addresses dependent eligibility for specific insurance plans that offer dependent coverage. The Eligible Dependent information below also includes federal requirements.

Eligible Dependent: a child who is a natural born, legally adopted or placed for adoption, or a child for which the certificate holder is the legal guardian and who is:

Age 25 or younger
Age 26-29 and they satisfy all of the following:

- Unmarried;
- An Illinois resident;
- Served as a member of the active or reserve branches of the United States Armed Forces; and
- Has received a discharge (*not* dishonorable) from the United States Armed Forces. Proof must be submitted using a form approved by the Illinois Department of Veterans' Affairs verifying the date the dependent child was released from service.

Adding dependents during open enrollment: Eligible dependents may be added to an in force certificate if they are added during either of the open enrollment periods described below:

1. Initial Open Enrollment for new customers that are being issued a certificate with an effective date June 1, 2009 and later:
   - Members can enroll eligible dependents during a 90-day period following the issue date or effective date of the certificate, whichever is later.

2. Subsequent Annual Open Enrollment periods:
   - Members can enroll eligible dependents during the 30 days prior to the certificate anniversary date.
   - In order to be eligible for the annual open enrollment, the eligible dependent must have a minimum of 90 days of continuous coverage without a break in coverage of more than 63 days.

     Please note that proof of prior creditable coverage will be required. Proof may include a certificate of creditable coverage or a billing statement from the prior carrier. If proof of prior coverage is not received, the dependent child will be subject to standard underwriting guidelines during the annual open enrollment.

For further information or to receive an application, please contact customer service at 800-553-7654.

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Form 30040 (Rev. 1/2011)

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. You should have the following information available, for each person requesting coverage:
   - Social Security Number, date of birth, and height/weight;
   - Information about any current or prior insurance coverage in effect within the last 12 months; and
   - Personal health information. If you do not have enough information to respond to a question, you should obtain any required information from your current or former health care provider(s).
5. 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 current 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: _______________________

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.)

Print Primary Applicant's Name ____

You have four choices for billing. It's important to note we'll request funds as soon as we issue your policy.

BILLING

You have four billing methods to choose from:

1. Monthly payroll deduction (list bill)

➜ Assigned list bill number, if known: ___________________

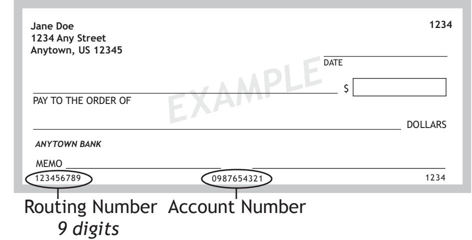
Note to agent: This option requires the employer have a list bill agreement on file.

We recommend you pick a an Electronic Funds Transfer (EFT)/Check-O-Matic draft date that is the same as your effective date.

2. Monthly Electronic Funds Transfer (EFT)/Check-O-Matic

➜ To begin withdrawals:
Select a desired withdrawal date 1-28:_______

Bank name:_________________________________
City:________________ State:__________________
Routing number: __ __ __ __ __ __ __ __ __
Account number:____________________________



Routing Number *9 digits* Account Number

➜ To add this policy to an existing Electronic Funds Transfer (EFT)/Check-O-Matic

Existing Electronic Funds Transfer (EFT)/Check-O-Matic number: ____

Associated policy number: ____

The accountholder's signature is needed here if requesting Electronic Funds Transfer (EFT) /Check-O-Matic.

Authorization for Electronic Funds Transfer (EFT)/Check-O-Matic — **please sign below**
I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Accountholder signature: ____ Date: __________

You have two options if choosing to pay by credit card — recurring or 1st payment only.

3. Credit card

➜ Choose how often: ☐ Quarterly ☐ Semi-Annual ☐ Annual
or
➜ ☐ Charge first payment only*

**You must also select a secondary billing method other than payroll deduction (list bill) for subsequent payments. Once you choose below, go to that section and complete.*

Choose method: ☐ Payroll deduction (list bill)
☐ Monthly Electronic Funds Transfer (EFT)/Check-O-Matic
☐ Bill me directly

The cardholder's signature is needed here if requesting to pay by credit card.

Authorization for credit card payments — **please sign below**
I authorize Time Insurance Company to charge my account for the Individual Medical policy listed above. I understand there will be no refund of premium after the 10-day free look in the contract.

Card number: ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___

Card type: ☐ MasterCard ☐ VISA

Expiration date: ____/____

Name as it appears on card: ____

Address of cardholder, if different:____

Cardholder signature: ____ Date:__________

4. Bill me directly:

➜ Choose how often: ☐ Quarterly ☐ Semi-Annual ☐ Annual

Please complete this if your billing address is different than your home address.

If your billing address is different than your home address, please enter it here:

Billing Address: ____
(Street) (City) (State) (ZIP)

Name of person paying, if different:____

FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO 414-299-6020

Health Advocates Alliance Membership Application

Health Advocates Alliance is a membership organization that promotes good health among its members and their communities. Membership in the Alliance is required in order to be eligible for health insurance coverage. Membership privileges include the right to participate in all programs offered or sponsored by the Association. For additional information and benefits provided by the Association please see the Health Advocates Alliance Brochure, form JI-1033.

I hereby request enrollment in the Health Advocates Alliance. I understand that nominal dues are required for membership in the Association; if participating in a sponsored insurance program, then my annual dues may be collected in installments along with my insurance premiums. I also understand that membership dues are non-refundable, and my failure to remit membership dues will result in loss of eligibility to participate in any of the Association sponsored programs or benefits.

____

Member Name *(please print)*

____

Member Signature Date

PLEASE RETAIN A COPY FOR YOUR RECORDS **PLEASE FAX TO: 414-299-6020**

ASSURANT
Health®

Print Primary Applicant's Name ____

Employer Sponsored Business Questionnaire

The purpose of this statement is to obtain the information necessary to determine eligibility for medical coverage offered to individuals and families. We appreciate your cooperation.

I am knowingly applying for individual health insurance coverage. I understand that this is not small group coverage. I further understand and agree that this application for health insurance will be fully medically underwritten and that coverage is not guaranteed. I certify that my employer is not contributing in any way toward the payment of my premium.

My signature indicates that I have read and understand this statement and that the statement is true to the best of my knowledge and belief.

____

Signature of Proposed Insured   Date

ASSURANT Health®

Underwriting Authorization

Application Number *(if known)* ______________________________

Name of Proposed Insured(s): ______________________________
(PLEASE PRINT)
____

Address: ______________________________

____

____

In order to determine my (our) eligibility for insurance, I authorize any licensed physician, medical practitioner, hospital, clinic, any pharmacy, pharmacy benefit manager or pharmacy-related entity, any medically-related facility, insurance company, MIB, Inc., employer, or consumer-reporting agency to give Time Insurance Company (or any consumer-reporting agency authorized by Time Insurance Company) any information regarding me or my family as to employment, other insurance coverage, personal information, and medical or pharmacy care, advice or treatment, or medication use.

I represent to the best of my knowledge and belief, that all statements and answers on Part 1 are complete and true. My recorded Personal Health History, Part 1 and any amendments shall be the basis for the contract. I also agree that: (1) Within 30 days of policy delivery, I must formally accept the offer by verifying the accuracy of the enrollment form information with a signature and returning that signed acceptance to Time Insurance Company. (2) Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company and accepted by me. (3) I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker. (4) If any of these conditions are not met, Time Insurance Company has the right to rescind its offer of coverage and the full extent of its liability shall be limited to the sum received.

I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, MIB, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, EMSI and its agents.

This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to MIB, Inc. and any medical records company engaged by Time Insurance Company, including but not limited to EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.

I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for Time Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.

Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: 30 days after denial of my application, or declination of enrollment, or, if insured, 30 days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than 24 months from the date signed.

______________________________ ______________
Signature of Primary Proposed Insured or representative* Date

______________________________ ______________
Signature of Spouse or Other Insured (s) or representative* Date

______________________________ ______________
Signature of Other Dependents 18 or over (if proposed to be insured) Date

*If you are the individual's representative and are not the parent or legal guardian of a minor, you must attach documentary evidence of your authority to act as the individual's representative for this authorization to be valid.

PLEASE RETAIN A COPY FOR YOUR RECORDS **PLEASE FAX TO: 414-299-6020**

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.

ILLINOIS INDIVIDUAL HEALTH INSURANCE ADDITIONAL NOTICES

NOTIFICATION REGARDING MIB, Inc. ("MIB") formerly known as the MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Time Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

PRIVACY

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.

CONDITIONAL RECEIPT

This Conditional Receipt is received from ____ , this _____________ day of

__________________ *(month)* ______________ *(year)*.

If full premium is paid and Time Insurance Company accepts this application as applied for within (30) days of the date the application is signed, the effective date will be as specified above, but I agree that I have no insurance coverage under this application until Time Insurance Company notifies me in writing that my application is approved. No agent or broker of the Company is authorized to alter or waive the conditions of this conditional receipt.

For coverage to become effective, each individual to be covered must be a risk acceptable to Time Insurance Company as applied for and at a standard or preferred rate with no Special Exception Riders on the later of: the Requested Effective Date or the Date on which Time Insurance Company receives the application at its home office.

I understand that Time Insurance Company has the right to deny my application and if it does so I will be notified in writing and the premium I submitted will be returned.

If I do not select an effective date, Time Insurance Company will assign an effective date that is later than the date the application is approved.

I must advise Time Insurance Company of any change in information included in the application for me or any person to be insured that occurs after the date I sign the application until the later of the effective date of coverage or the date Time Insurance Company receives the application at its home office. Failure to update Time Insurance Company regarding these changes may result in coverage being voided.