Illinois Standard Health Employee Application for Small Employers

INSURER USE ONLY
Policy/Group No.
Section No.
Effective Date
New Hire Waiting Period

For assistance in completing this application, please contact your employer or insurance agent. For information about your health insurance rights under state and federal law, and other resources, please contact the Illinois Department of Insurance's Office of Consumer Health Insurance toll free at (877) 527-9431.

This standard application is intended to simplify your health insurance application process. You will only need to complete this one application, even when your employer has requested quotes from multiple insurance companies.

The information you provide in this application will be sent to the following insurance companies:
(To be completed by employer)
Insurer: _____ Insurer: _____ Insurer: _____
Insurer: _____ Insurer: _____ Insurer: _____

TO BE COMPLETED BY EMPLOYER

Employer Name: The Dana Point CA Phone #: 847-228-5176

Address: 1519 E. Central Rd. Arlington Heights, IL 60005

Reason for Enrollment (Mark all that apply)

New Enrollment: ☒ New Group ☐ Open Enrollment ☐ New Hire (Date: _____) ☐ Late Enrollee

Special Enrollment: ☐ Adoption ☐ Court Order ☐ Dependent Addition ☐ Divorce ☐ Domestic Partner
☐ Loss of Coverage ☐ Marriage ☐ Newborn ☐ Other Date of Event: ____/____/____

Employment Status: ☒ Active ☐ Retiree (Retirement Date: ____/____/____)
☐ Illinois Continuation ☐ COBRA
☐ Employee ☐ Dependent
Qualifying Event: _____
Start Date ____/____/____ Projected End Date ____/____/____

A Employee Information

Name (Last) Valle-Contrero (First) Manuel (MI) .

Job Title: Maintenance Man Hire Date: 1/1999 Hrs/Week: 40/w

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner

Home Address: 8953 Robin Dr. Unit F Apt #:

City: Des Plaines State: IL Zip: 60016

Home (or Cell) Phone: (847) 962-5243 Business Phone: ( )

Email Address (optional):

B Coverage Requested

Medical

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

Plan Choice: Plan Choice: Plan Choice:

If you are **waiving (declining)** coverage for yourself or any member of your family, you must complete Section C below.

Employer Name The Dana Point Employee Name Manuel Valle Contreras

C Waiver of Coverage

Please complete this section only if **you are waiving (declining) coverage** for yourself or one or more of your family members.

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer.

I understand and agree:

- If I am declining coverage for myself, my spouse/domestic partner, or my dependent child(ren) because of other coverage, I may in the future be able to enroll myself, my spouse/domestic partner, or my dependent child(ren) provided that I request enrollment within 31 days after the other coverage ends.
- If I have a new spouse/domestic partner or child as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my new spouse/domestic partner or child provided that I request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- If I decide to request coverage in the future, for a reason other than the termination of other coverage or the addition of a new spouse/domestic partner or child, I may be considered a late enrollee, if applicable, or I may have to wait until the plan's next open enrollment period. I also understand that as a late enrollee, coverage for preexisting conditions may be excluded for up to a period of 18 months. This period may be offset by the time I, my spouse/domestic partner, or my dependent child(ren) was covered under a qualified health plan.

I certify that I was not pressured, forced, or unfairly induced by my employer, the agent, or the insurer(s) into waiving or declining the group coverage.

I DO NOT want, and hereby waive, coverage for (initial next to all that apply):

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

* If offered.

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

☐ Spouse/Domestic Partner's Employer Plan ☐ Individual Coverage (Non-Group Plan)
☐ COBRA/State Continuation ☒ Medicare or other Government Program
☐ Other (please explain): _____

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

Employer Name _____ Employee Name _____

I Acknowledgement & Signature

I understand, agree, and represent that:

- I have read this document or it has been read to me.
- The answers provided within this entire application for coverage are, to the best of my knowledge and belief, true and complete.
- Neither my employer nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of the insurance carrier's other rights and requirements.
- I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by the insurer. I understand that if I intentionally omit or provide false information on or in relation to this application that I may face legal liability, including legal action based on fraud.
- If this application for coverage is accepted, coverage will be effective on the date specified by the insurance carrier on the certificate of coverage/certificate of insurance.

I hereby enroll for benefits as indicated in Section B and Section H of this application, for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice.

I understand that the information I have provided in this application will be used by the insurance carrier and its affiliates to make decisions regarding eligibility, enrollment, underwriting, and premium risk rating.

I understand that the medical information provided also includes my spouse/domestic partner and/or dependents' information.

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

I understand that I should retain a duplicate copy of this application for my own records.

A photographic copy of this acknowledgment shall be as valid as the original.

I authorize the insurance carrier to electronically transmit the information contained herein.

If this application was taken over the phone or on the computer, I acknowledge that I, myself, have not actually signed this application but instead hereby authorize the insurance carrier to print "Electronically Acknowledged" on the signature line of the application and I agree that such printing shall be treated as a valid signature for all purposes of this form. I acknowledge that the insurance carrier has verified my identity for this purpose in accordance with any applicable law or regulation.

By signing below, I acknowledge that I have read and understand this document and I am signing of my own free will.

Employee Signature X [signature] Date 6/24/13

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