



# Eligibility and Enrollment Application

Illinois Comprehensive Health Insurance Plan

[www.chip.state.il.us](http://www.chip.state.il.us)

Each Person Applying for Coverage Must Complete a Separate Application

## Step 1:

### Applicant Information – Who is Applying for Coverage?

(Throughout this application, the terms “you”, “I” and “my” refer to the applicant.)

Provide Information about the applicant.

1. \_\_\_\_\_  
*First Name Middle Name Last Name*

2. \_\_\_\_\_  
*Residential Address (P.O. Box or Business Address is not acceptable)*

\_\_\_\_\_  
*City State Zip Code County*

3. \_\_\_\_\_  Male  Female  
*Social Security Number Birth Date MM/DD/YYYY Age*

4. \_\_\_\_\_  
*Home Phone Work Phone Cell Phone*

5. Have you used tobacco within the past 12 months?  Yes  No  
*If no, upon enrollment you will be sent a certification form regarding tobacco usage.*

6. If two or more family members are applying, identify the oldest applicant:  
\_\_\_\_\_  
*First Name Middle Name Last Name Social Security Number*

7. Are you between 18-23 years old and a full time student?  Yes  No  
*If yes, provide a copy of your most recent class schedule and parent's federal tax return for the most recent tax year.*

8. Marital Status:  
 Single  Married  Widowed  Divorced/Separated Date \_\_\_\_\_  
*Provide the date when widowed, divorced, or separated. MM/DD/YYYY*

9. \_\_\_\_\_  
*Spouse Name if the applicant is married Social Security Number*

10. \_\_\_\_\_  
*Custodial Parent/Guardian Name if the applicant is a minor or is legally incompetent. Social Security Number*  
*If applicant is legally incompetent we require a copy of the Legal Guardianship documents.*

11. Are you a U. S. Citizen?  Yes  No  
11a. If no, are you a lawful permanent resident alien?  Yes  No

12. Are you an Illinois Resident?  Yes  No  
12a. Date you became a permanent Illinois resident. \_\_\_\_\_  
*If a resident since birth, use date of birth. MM/DD/YYYY*

13. Have you received or are you now receiving Social Security Disability?  Yes  No  
13a. If yes, provide the eligibility start date and end date for Social Security Disability and submit a copy of your disability award letter.

\_\_\_\_\_  
*Eligibility or Start Date MM/DD/YYYY Termination or End Date if applicable MM/DD/YYYY*

14. Have you applied for (but are not yet receiving) Social Security Disability?  Yes  No  
*Submit a copy of the most recent correspondence received from the Social Security Administration.*

15. If you are at least 19 but not yet 30 years of age and are single, widowed or divorced, answer both questions 15a and 15b below:

15a. Are you a military veteran?  Yes  No

15b. Are your parents insured under a group or individual health plan?  Yes  No  
*If yes, please submit a complete copy of that health insurance policy, verification of the renewal date, and verification of your individual premium rate for that coverage.*

## Step 2: Coverage Options

Indicate the coverage options.

1. How do you qualify for coverage?
  - HIPAA** You recently lost group coverage and have exhausted COBRA or other continuation coverage.
  - Traditional** You cannot obtain health insurance due to health reasons or have substantially similar coverage that costs more than the individual Traditional rate.
  - Medicare** You are under 65 and enrolled in Medicare Parts A and B.
  - HCTC** You qualify for the Health Coverage Tax Credit (HCTC). For this coverage the applicant, or a family member, must have HCTC certification from the federal government. If you choose this HCTC coverage option, we will send an HCTC addendum application to complete. For HCTC, skip steps 5, 6, 7 and 8.
2. Choose a calendar year deductible option from either 2a or 2b below:
  - 2a. Standard Deductible options:  
 \$500     \$1,000     \$1,500     \$2,500     \$5,000
  - 2b. High Deductible Health Plan (HDHP) deductible options; for use with a Health Savings Account (HSA); all charges, including drugs, are subject to the deductible.  
 \$1,200     \$2,000     \$5,200  
*HDHP deductibles are not available with Medicare coverage.*
3. For Traditional or Medicare Plans, do you want to purchase maternity coverage?     Yes     No  
*Maternity coverage is automatically included in the HIPAA and HCTC plans.*
4. How will the premium be paid?     monthly bank draft     quarterly     semiannually  
*Monthly is only available through a bank draft and requires 2 months' premium when first enrolled to allow time to set up the process.*
5. Who will be paying the premium?     Applicant/Spouse     Spouse     Parent     Other  
(joint account)    (non-joint account)

If Other, explain: \_\_\_\_\_

## Step 3: Most Recent Health Insurance/Health Plan Information

Tell us about past and present health coverage.

1. Do you have or have you ever had health insurance coverage?     Yes     No  
*If no, go to question 4 of this step.*
2. When will or did this health insurance coverage end? \_\_\_\_\_  
*MM/DD/YYYY*
  - 2a. Describe the type of health insurance coverage:  
 Group Health Plan or Group Insurance Coverage     Medicare     Medicaid     Church Plan  
 Individual Health Insurance Policy     Federal or other Government Employees Plan  
 CHIP or other State Risk Pool     Other (describe) \_\_\_\_\_
  - 2b. Why did coverage end? \_\_\_\_\_
3. \_\_\_\_\_  
*Insurance company name or health plan name    Policy number or plan number    Phone number including area code*
4. Are you eligible for Medicare?     Yes     No  
*If yes and enrolled, provide a copy of the Medicare ID card.*
  - 4a. If yes, is there any other insurance that supplements Medicare?     Yes     No
  - 4b. \_\_\_\_\_  
*Name of Supplemental Insurance    Policy Number*
5. Are you receiving or approved to receive any type of Medical Assistance including All Kids from the Illinois Department of Healthcare and Family Services, or like agencies?     Yes     No
  - 5a. If yes, provide the Medical Assistance ID number(s). \_\_\_\_\_

## Step 4: Employment Information

We require employment information for you and/or your family. For example, if you and your spouse are employed, provide information for both. If the applicant is less than 18 years old, a student, or legally incompetent, provide information for all those in the family that are employed. We require employment information for divorced or separated parents or legal guardians, even if they do not live in the same home.

1. Are you, or any person in your family, employed?  Yes  No

2. Provide current or most recent employment information for Person #1:

2a. \_\_\_\_\_  
*Employed Person #1 Name* *Relationship to Applicant*

2b. \_\_\_\_\_  
*Employer Name* *Employer Phone Number*

2c. \_\_\_\_\_  
*Employer Address* *Termination Date MM/DD/YYYY*

2d. \_\_\_\_\_  
*Employer City* *Employer State* *Employer Zip*

2e. Employed as:  Full Time  Part Time  Self Employed  Retired

2f. Is health insurance offered?  Yes  No

2g. Is the applicant eligible?  Yes  No

2h. If not eligible, explain: \_\_\_\_\_

3. Provide current or most recent employment information for Person #2:

3a. \_\_\_\_\_  
*Employed Person #2 Name* *Relationship to Applicant*

3b. \_\_\_\_\_  
*Employer Name* *Employer Phone Number*

3c. \_\_\_\_\_  
*Employer Address* *Termination Date MM/DD/YYYY*

3d. \_\_\_\_\_  
*Employer City* *Employer State* *Employer Zip*

3e. Employed as:  Full Time  Part Time  Self Employed  Retired

3f. Is health insurance offered?  Yes  No

3g. Is the applicant eligible?  Yes  No

3h. If not eligible, explain: \_\_\_\_\_

## Step 5: Complete this step if HIPAA coverage was selected in Step 2

This step is for those who selected HIPAA coverage at Step 2.

1. Are you eligible for Medicare and applying for HIPAA due to the six-month pre-existing condition exclusion under the Medicare Plan?  Yes  No

2. Have you been covered by prior creditable coverage for at least 18 months as of the date shown at Step 3 Question 2?  Yes  No

3. With regard to the most recent prior coverage, did coverage terminate due to:

<input type="checkbox"/> end of COBRA / continuation period	<input type="checkbox"/> non-payment of premium
<input type="checkbox"/> cancellation / non-renewal by issuer	<input type="checkbox"/> fraud
<input type="checkbox"/> business closed / bankruptcy	<input type="checkbox"/> employer terminated entire Group Health Plan
<input type="checkbox"/> other reasons; specify: _____	

4. Was or is there continuation of coverage under COBRA or similar State Continuation laws? *If no, go to question 5 of this step.*  Yes  No

4a. If yes, provide the following information regarding the former employer and insurer:

\_\_\_\_\_  
*Name of former employer* *Phone # of former employer*

\_\_\_\_\_  
*Address of former employer* *City* *State* *Zip*

\_\_\_\_\_  
*Name of Group Plan or Insurer* *Policy #* *Phone # of Insurer*

\_\_\_\_\_  
*Address of Group Plan or Insurer* *City* *State* *Zip*

4b. Dates of COBRA/State Continuation: \_\_\_\_\_  
*From Date MM/DD/YYYY* *To Date MM/DD/YYYY*

4c. Identify the qualifying event that allowed the applicant to elect continuation of coverage:

- Resignation or Termination       Disability       Reaching the limiting age  
 Retirement of spouse       Retirement       Reduction in hours  
 Death or Divorce of spouse

4d. Have you now or will you soon exhaust all continuation of coverage options?       Yes       No

5. Other than continuation coverage, are you now eligible for or covered by any other group coverage?       Yes       No

6. Are you eligible for or covered by any other health insurance?       Yes       No

7. If either 5 or 6 above is yes, provide the following information regarding this coverage:

<i>Name of plan or insurer</i> <i>If you have other health insurance, provide a copy of that policy.</i>	<i>Description of coverage</i>	<i>Policy or plan number</i>
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8. Will your current health insurance coverage terminate?       Yes       No

8a. If yes, what date will this coverage terminate?

\_\_\_\_\_  
*Term Date MM/DD/YYYY*

### **Step 6: Complete this step if Traditional coverage was selected in Step 2**

1. Within the last nine months, have you been rejected or refused comprehensive coverage due to health reasons?       Yes       No

2. If you answered "no" to question 1, do you have one of the presumptive medical conditions as outlined in the Summary of Coverage?       Yes       No

### **Step 7: Complete this step if Medicare coverage was selected in Step 2**

1. Within the last nine months, have you been rejected or refused Medicare supplement coverage due to health reasons?       Yes       No

2. If you answered "no" to question 1, has your Medicare Part B been in effect for more than six months?       Yes       No

3. If you answered "yes" to question 2, do you have one of the presumptive medical conditions as outlined in the Summary of Coverage?       Yes       No

### **Step 8: Complete this step if Traditional or Medicare coverage was selected in Step 2**

1. Do you currently have health insurance?       Yes       No  
*If yes, provide a copy of the premium notice verifying the individual rate and a complete copy of the policy.*

2. Have you ever been enrolled in CHIP before?       Yes       No

2a. If yes, provide the dates of previous coverage. \_\_\_\_\_  
*From Date MM/DD/YYYY* *To Date MM/DD/YYYY*

3. Are you a resident of a public institution?       Yes       No  
*For example, a mental health center or a prison.*

4. Is the CHIP premium to be paid for or reimbursed by any government sponsored program or by any governmental agency or health care provider?       Yes       No

5. Identify your primary health condition: \_\_\_\_\_  
*Identify the primary health condition that prevents you from obtaining standard insurance coverage.*

6. Have you ever been injured by anyone else who might be legally liable to you because of damages they caused that resulted in your injury?       Yes       No  
*If yes, a Third Party Liability Supplemental Application will be sent for completion.*

### **Step 9: Illinois Insurance Producer**

1. Did a licensed Illinois insurance producer assist with this application?       Yes       No  
*If yes, complete the Insurance Producer Information and Authorization form.*

## Step 10: Required Documentation

### For All Applicants:

1. To prove Illinois residency, attach a copy of your current valid Illinois driver's license, an ID card issued by the Illinois Secretary of State or the most recent resident Illinois Income Tax Return (IL-1040). This documentation must reflect the current residential address. Refer to the Summary of Coverage Brochure for additional information about residency.
2. If you are a lawful permanent resident alien, attach a copy (front and back) of the USCIS I-551 form (green card).
3. If any employer identified in Step 4 does not provide, offer, or arrange for health insurance coverage or a group health plan for any of its employees, attach a statement to that effect from each such employer.
4. If you are not eligible for any health insurance coverage or group health plan which is provided, offered or arranged by applicant's, spouse's or parent(s)' employer, attach a copy of the eligibility section of the group health plan booklet and a written statement from each employer outlining the reason that the applicant is not eligible.
5. If you are currently insured (other than under COBRA or State Continuation), attach a copy of the policy.

### If Traditional or Medicare coverage was selected at Step 2:

6. For the Traditional plan, attach a copy of a rejection letter dated within the last nine months and signed by an underwriter from a health insurance issuer or plan for comprehensive coverage stating that you are ineligible due to health reasons; or
- 6a. For the Medicare plan, attach a copy of a rejection letter dated within the last nine months and signed by an underwriter from a health insurance issuer or plan for a Medicare supplement stating that you are ineligible due to health reasons; or
7. Attach a copy of a physician's statement verifying that you have one of the physical or medical conditions considered by the plan to be a presumptive medical condition. (See the Summary of Coverage Brochure for a listing of our presumptive medical conditions); or
8. Attach a copy of the notice of refusal to issue or renew substantially similar coverage except at a rate exceeding the applicable CHIP plan rate. You must also submit a copy of the premium notice showing the individual rate (for medical coverage only) that you or a member of your family is directly responsible for paying.

### If HIPAA coverage was selected at Step 2:

9. Submit a copy of any "certificate of creditable coverage" that proves that you have had at least 18 months of creditable coverage without a break of more than 90 days at a time. If you did not receive this certificate, contact the former employer or carrier and request one.
10. Submit a copy of any letter or notice received from a former employer that verifies the starting and ending dates of any COBRA or other continuation period you were eligible for, and a copy of the termination letter or notice that describes the date and reason the continuation coverage ended and proof of final payment (front and back of cancelled check and premium notice, or a statement from the insurance company or former employer).

**If HCTC coverage was selected at Step 2 see the HCTC Application Addendum for required documentation.**

## Step 11: Important Information

Do not send money with the application. We will contact you with additional information about premiums when processing of the application is complete. Premium rate tables can be found at [www.chip.state.il.us](http://www.chip.state.il.us) or from the Board Office toll free at 866-851-2751.

You will not be able to enroll or have any coverage under this state program until the application and any subsequent information has been approved and payment for the full initial premium has been received and honored.

If applying for Medicare or Traditional coverage, benefits will not be provided for any pre-existing conditions until six months after the effective date of coverage. A pre-existing condition is any condition for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period immediately preceding the effective date. Medical treatment includes prescription drugs.

By your signature below, you agree to the following statements:

- ▶ My responses as recorded in this application are full, complete and true to the best of my knowledge and belief.
- ▶ I am not currently covered under any group health plan, any other health insurance coverage, Medicare, medical assistance provided by the State of Illinois or any other state except as disclosed in this application. Any coverage that ultimately may be issued will terminate as of the date that I obtain or become eligible for other coverage as described above.
- ▶ Any coverage provided by the Illinois Comprehensive Health Insurance Plan (CHIP) will be based on the information disclosed in this application, a copy of which will be attached to and made a part of any benefit plan booklet which may be issued to me.
- ▶ No plan coverage will be effective unless and until guaranteed payment for the initial premium has been received and honored and all other requirements have been met and approved by CHIP.
- ▶ Any plan coverage issued can be rescinded as of the original issue date if it is later determined that any of the information contained in or supplemental to this application is false or inaccurate.
- ▶ I will immediately lose my eligibility for CHIP if I move outside the State of Illinois.
- ▶ I authorize any insurance issuer, insurance service or organization, group health plan, administrator, provider, institution or person that has my records or knowledge of my health history to give such information to CHIP or its designated representative.

E-mail Address

To ensure that information is kept confidential, always encrypt e-mail transmissions.

Signature of Applicant

Date

Be sure to sign and date this application.

Signature of Custodial Parent if applicant is a minor or Legal Guardian if legally incompetent

Date

Have You?

- Completed a separate application for each person applying for coverage?  Yes  No
- Signed and Dated the Application?  Yes  No
- Answered all questions completely?  Yes  No
- Attached all documents as required?  Yes  No
- Carefully read and reviewed all your answers to ensure their accuracy?  Yes  No

**Step 12: Forward this Application and all documentation to:**

Send it to our office for prompt processing.

Illinois Comprehensive Health Insurance Plan  
320 West Washington Street, Suite 700  
Springfield, Illinois 62701-1150

If you have questions you can call toll free at 866-851-2751.