



Application Instructions

It takes about 45 minutes to complete an application. Allow yourself ample time to read and understand all questions. In addition, you will be asked to provide various documents related to your identity, employment, and insurance history.

There are five plans to choose from:

- Plan 2 – for persons who are enrolled in Medicare Parts A and B due to disability or kidney failure.
- Plan 3 – for persons who have been denied major medical coverage by private insurers because of health or whose premiums are higher than CHIP.
- Plan 5 – for persons who have recently lost group coverage and have exhausted their COBRA or other continuation options.
- Plan T – for persons who are not enrolled in Medicare and who have recently lost coverage and are certified for Trade Adjustment Assistance (TAA) because of a loss of job impacted by foreign trade.
- Plan P – for persons who are between the ages of 55 and 65, not enrolled in Medicare, and are receiving a pension from the Pension Benefit Guaranty Corporation (PBGC).

Use the ICHIP Eligibility and Enrollment Application if you are applying for Plans 2, 3 or 5. Use the TAA Eligibility and Enrollment Application if you are applying for Plans P or T.

To apply for coverage, follow these instructions:

1. Complete all appropriate sections of the application.
2. Date and sign the form.
3. Review your completed application for accuracy. NOTE: Failure to comply with all requirements in applying for CHIP may delay the processing of your application and the issuance of any subsequent coverage that may be approved.
4. Attach all requested documentation. Refer to Step 8 instructions for a complete description of documentation that is needed.

Turn the page for complete, step-by-step instructions. If you have any questions about how to complete the application, call toll-free 866-851-2751.

Step-by-Step Instructions for completing the CHIP application for Plans 2, 3, or 5

Step 1. Applicant Information

Use this section to disclose personal information about the person for whom coverage is intended. Complete a separate application for each applicant, even if the applicant is a minor.

- Q 1** The full name of the person for whom coverage is being requested.
- Q 2** The residential street address of the applicant. Provide the address where the applicant physically resides. Do not provide a business address or a Post Office Box. Rural box numbers are acceptable provided you include the rural route number and box number. If you would like to receive mail at an address other than your residential address, make a request in writing telling us the address where you would like mail to be sent and why mail should be sent to this alternate address.
- Q 3** Fill in the city, state, zip code, and county where the applicant physically resides.
- Q 4** Provide the Social Security Number, date of birth, current age, and gender of the applicant.
- Q 5** Provide phone numbers where you can be reached: home, work, and cell if available. All telephone numbers are optional, but will assist us in contacting you if we have any questions about your application.
- Q 6** Provide the e-mail address for the applicant. If you do wish to communicate using e-mail, all identifying and health information should be encrypted. Any e-mail we send to you will have identifying and health information in an attached file that is encrypted and password protected. You will need to call our toll-free number to obtain the password that we will assign so that you can access this information. This unique password will be used for all e-mail correspondence.
- Q 7** Complete this question only if you are applying for coverage as a dependent. The primary applicant or participant is the oldest adult family member to be insured. Family rates are available if at least one adult and one additional family member are enrolled in the same plan and deductible option. Therefore, in order to obtain coverage at the most affordable rate, you must complete this question.
- Q 7a** This question is to be answered if you answered Q 7 and you are a dependent between the ages of 18 and 23. In order to be eligible for the family rate, you must be a dependent and a full-time student. Provide proof of your full-time student status by sending a copy of your most recent class schedule. Provide proof that you are a dependent by sending a copy of your parent's most recent federal tax return.
- Q 8** Indicate your marital status using the following definitions:
- Single – never been married.
 - Married – currently legally married.
 - Widowed – spouse is deceased and you have not remarried.
 - Divorced/legally separated – Divorce means a legal court approved divorce. A legal separation is a court approved separation. If the applicant is legally separated, provide a copy of the legal separation order.
- Provide the date you became widowed or divorced, if applicable.
- Q 9** Provide your spouse's full name and Social Security Number if you are married, even if the spouse is not applying for coverage.
- Q 10** If the applicant is a minor or a person who is not otherwise legally competent, tell us the name and Social Security Number of the custodial parent or legal guardian, even if the custodial parent/legal guardian is not applying for coverage. Only the custodial parent or legal guardian may apply on behalf of the minor or legally incompetent person. If legally incompetent, please submit a copy of guardianship papers or power of attorney documentation.

- Q 11&11a** Answer these questions about your US citizenship or lawful permanent resident alien status. If you are a U. S. citizen, no documentation to that effect is required. If you are a lawful permanent resident alien, provide a photocopy of the front and back of your I-151 or I-551 green card.
- Q 12** Answer yes or no to this question. If you are not an Illinois resident, you are not eligible for CHIP coverage.
- Q 13** Provide the date that you most recently became a permanent resident of Illinois. Please indicate a month, day and year. Provide the date you moved to Illinois, or, if you have been an Illinois resident your whole life, enter your birth date.
- Q 14** Answer yes in the following instances:
- if you have ever received Social Security Disability, even if you are not currently receiving it; or
 - if you currently receive Social Security Disability.
- Provide a copy of your Social Security Disability award letter.
- Q 14a** Provide the month, day and year that you first became eligible for Social Security Disability and, if applicable, the month, day and year that your Social Security Disability ended. Submit documentation verifying the termination date.
- Q 15** If you have applied for Social Security Disability but have not yet been approved or have not yet received your first Social Security Disability check, provide a copy of the most recent correspondence that you have received from the Social Security Administration.
- Q 16** Answer yes if you are eligible for Medicare due to total disability or end-stage renal disease/kidney transplant. Provide a copy of your Medicare ID card. If you are eligible for Medicare due to age, you are not eligible for CHIP coverage.
- Q 16a & b** If you are eligible for Medicare and have any sort of Medicare supplement insurance, answer yes. In Q 16b, provide the name of the Medicare supplement insurance and your policy ID number. Submit a copy of the policy and proof of premium.
- Q 16c** If you are eligible, you can enroll in Plan 5 for the first six months of coverage so that you will not be subject to Plan 2's six-month preexisting condition limitation. After six months, your coverage will be moved to Plan 2.
- Q 17 & 17a** Answer yes if you are currently receiving or if you have been approved to receive any sort of medical assistance, including KidCare from Illinois or from any other state public aid or human services department or agency. If you checked yes, provide your Medical Assistance/KidCare ID number in Q 17a. Enrollment in Plan 5 will be denied if you are currently receiving or approved to receive medical assistance. You may be eligible for Plans 2 or 3 if enrolled in the Illinois Medical Assistance spend-down program, but only for the first six months of coverage in Plan 2 or 3. After this initial six-month period, you must drop your medical assistance in order to continue in Plan 2 or 3.

Step 2. Coverage Options

In this section, select the type of coverage, deductible, and rate payment methods you prefer.

- Q 1** Mark which plan you are applying for – Plan 2, 3 or 5. If you qualify for Plans P or T, complete the TAA application instead.
- Q 2** Decide which calendar year deductible option you want. Each plan has a choice of five different deductibles: \$500, \$1,000, \$1,500, \$2,500, and \$5,000. Select the deductible that best fits your needs. Once you have enrolled, any deductible that has been selected cannot be decreased. Each active participant with a deductible of less than \$5,000 will be given the opportunity to increase the deductible annually. This can

only occur when a written request has been received and approved. Increases cannot be effective until the next January 1 after such election.

- Q 3** All plans have optional maternity benefits that provide incremental maternity coverage of up to \$4,000, depending on your rate area. Complications of pregnancy are automatically covered under the plan, same as any other sickness, regardless of whether the optional maternity benefits rider is purchased. However, benefits for normal delivery are not available unless you purchase an optional maternity benefits rider. This optional maternity benefits rider is available only at the time of initial application or within 60 days of marriage. If elected, this rider must be kept for a minimum of 12 months and requires payment of additional premium as shown in the premium rate table.

Rate Area A	County of Cook, City of Chicago only
Rate Area B	All of Cook County (except the City of Chicago), and it includes all of DuPage, Kane, Lake, McHenry and Will Counties
Rate Area C	All of Boone, Champaign, DeKalb, Grundy, Kankakee, Kendall, Madison, Peoria, Rock island, Sangamon, St. Clair, Tazewell, and Winnebago Counties
Rate Area D	All counties not included in A, B or C

Benefits can be purchased in \$500 increments, up to the maximum shown below:

Rate Area	\$500	\$1,000	\$1,500	\$2,000	\$2,500	\$3,000	\$3,500	\$4,000
A								
B								N/A
C							N/A	N/A
D						N/A	N/A	N/A

Refer to the rate table for additional information about the maternity benefits.

- Q 4** Decide how often you want to pay your premium. Once enrolled, if you choose a semi-annual or a quarterly premium frequency, you will receive a premium due notice about 40 - 45 days prior to each next premium due date. Monthly premiums can only be paid through a monthly bank draft method using either a checking or a savings account. Using this method, once enrolled, your bank account will be drafted every first, second, third or fourth Friday of the month. Once you are approved for coverage, you will be asked to decide which Friday of the month you want your account to be drafted.
- Q 5** If someone else is going to be paying your CHIP premium, a special authorization form may be required.

Step 3. Tell us about the most recent employment history of all adults in the household

NOTE: Answer each of these questions about yourself and, if you are married, about your spouse's employment, even if your spouse is not applying for coverage. If you are a minor, answer these questions about each parent. If you are single, do not answer the spouse/parent #2 column.

- Q 1** Employment refers to full- or part-time employment. Current employment refers to whether you are employed at the time you complete the application. Even if you know that your employment (or your spouse's or parent's employment) will end on a certain date in the future, answer this question based on the status as of the date the application is completed.

- Q 2** Answer no only if you (your spouse or parent) have never been employed outside of the home. If you answered yes to Q 1, skip Q 2.
- Q 3** Provide the month, day, and year of the date that you (your spouse or parent) were last employed.
- Q 4** Answer this question yes if the employer offers health insurance to any of its employees, even if you personally do not qualify or do not currently participate in this insurance plan.
- Q 5** If you were ever eligible for coverage through an employer's plan, answer yes, even if you never applied. If you answered no to Q 4, proceed to Q 7.
- Q 6** If you answered yes to Q 4, answer yes to this question if you ever applied, even if you were never actually covered or enrolled after you applied. If you applied for the group health insurance plan through your employer (your spouse's or parents' employer) and were denied, send us a copy of the declination notice.
- Q 7** Indicate the number of full-time employees. The options are: less than 20 employees (< 20); 20 or more employees (≥ 20).
- Q 8 & 8a/b** If you answer yes to Q 8, give the month, day and year that coverage ended and a brief explanation as to why the coverage ended. If you answer no to Q 8, skip Qs 8a and 8b.
- Q 9 - 11** Provide information about your current or most recent employer, your spouse's current or most recent employer and, if the applicant is a minor, your parent's current or most recent employers. Provide the employer's name, address, phone number and, if applicable, the month, day and year employment ended.

Step 4. Tell us about any current and previous health insurance coverage

Respond fully to each question.

- Q 1** Provide the month, day, and year that your most recent health insurance coverage ended (or will end). If you have never been covered by health insurance, mark that box instead.
- Q 1 a-b** Identify the type of your most recent coverage. Give a brief explanation as to why that coverage ended.
- Q 2** Provide the name, phone number, and plan/policy number of your most recent insurance company or health plan. Also, provide the month, day and year that coverage began and the month, day and year the coverage ended.

Steps 5 and 6. Plan-specific Information

Questions in Step 5 apply to Plan 5 only. Questions in Step 6 apply to Plans 2 and 3 only. Answer questions in Step 5 only if you are applying for Plan 5. Answer questions in Step 6 only if you are applying for Plans 2 or 3.

Step 5. Plan 5 Only

- Q 1** In order to qualify for Plan 5, your most recent prior coverage must be group type coverage. If your last most recent coverage was individual, you should skip this section and apply for Plan 2 or 3 under Step 6. If your last most recent coverage was group coverage, but it was for less than 18 months, provide documentation (a copy of the certificate of creditable coverage) of all coverage over the past 18 months, regardless of type.
- Q 2** Respond to this question only in relation to the last or most recent coverage. Check only one box.

- Q 3** Under most circumstances, COBRA rights are available. However, if the group is a small group or not subject to COBRA, Illinois has its own State Continuation laws that often provide continuation rights if COBRA is not applicable.
- Q 4** If you answered yes to Q 3, indicate the names, addresses and phone numbers of the former employer and the group plan or issuer. Also, fill in the plan or policy number.
- Q 5** Indicate the month, day, and year that continuation started and ended (or will end). Generally 18 months are available through COBRA. However, there are instances where 29 or 36 months are available. For employers that are not subject to COBRA, certain State Continuation rights may be available. Generally, nine months of State Continuation are available. However, there are instances where 24 months or longer are available.
- Q 6** COBRA and other continuation rights occur when a “qualifying event” happens. Please mark the reason why continuation of coverage was available.
- Q 7** Answer yes or no.
- Q 8** If you answered yes to Q 7, indicate the month, day and year that coverage ended (or will end).
- Q 9** Answer this question yes only if you are eligible for any other type of coverage other than COBRA or State Continuation.
- Q 9a** If you answered yes to either part of Q 9, indicate the name of the plan or issuer, the type of coverage and the policy/plan ID number.
- Q 10** Answer yes if you plan to terminate this other (non-COBRA or non-continuation type) of coverage.
- Q 11** If you answered yes to Q 10, indicate the month, day and year that this other coverage will be terminated.

Step 6. Plans 2 or 3 Only

- Q 1 - 3** Answer each of these questions if applying for Plan 2 or 3 only. At least one of these questions must be answered yes in order to qualify for Plan 2 or 3.
- Q 4** Tell us if you have previously been enrolled in CHIP. If so, give us the effective date and the termination date of your prior CHIP coverage.
- Q 5** Answer yes if you are currently residing in a mental health center or prison.
- Q 6** If anyone other than yourself will be paying for or reimbursing you for your CHIP premium, is that person or entity a governmental body or a health care provider?
- Q 7** Name the primary medical condition that prevents you from being able to obtain insurance in the private market.
- Q 8** Answer yes if you have ever suffered an injury that was or could be considered someone else’s fault, since they may be legally liable for your medical costs. We will then send you a special form to tell us more details about the incident.

Step 7. Producer question

- Q1** Answer yes if a licensed Illinois insurance producer assisted you in completing the application. Then, complete the Insurance Producer Information and Authorization form included in your packet of information.

Step 8. Required documentation

Residency Information

All applicants must furnish proof of Illinois residency. Provide proof of your Illinois residency by sending a copy (front and back) of one of the following items:

- Valid Illinois motor vehicle operator's license,
- Illinois Identification card,
- Illinois Disabled Person's Identification card, or
- Illinois Individual Income Tax Return for the most recent tax reporting period.

Proof of residency must show your current home address. If the applicant is under 18, the parent with whom the applicant lives must furnish this proof. For Plans 2 and 3, you must currently have been an Illinois resident for at least 180 days. For Plan 5, you must be an Illinois resident at the time of application. Resident means a person who has been and continues to be legally domiciled in Illinois. Legal domicile is established by the following: living in a place of permanent habitation within the State of Illinois which the person has established as his permanent home, and acquired by purchase, rental or other arrangement; maintaining his household equipment, furnishings and personal belongings at this permanent home; maintaining a current valid Illinois Driver's License or Illinois Identification Card or Illinois Disabled Person's Identification Card which is issued by the Secretary of State; being subject to and filing a resident Illinois State Income Tax return each year; and remaining physically present in Illinois for the foreseeable future except when absent for transitory or temporary purposes.

A child is considered legally domiciled in Illinois if both the child and his or her custodial parent(s) live in Illinois. A legally incompetent adult is considered legally domiciled in Illinois if both the legally incompetent adult and his or her legal guardian live in Illinois.

Once enrolled, the Plan may periodically require verification of residency and may also require additional information, documentation, or statements under oath from you to determine your residency for the entire term of coverage or for any portion thereof.

For All Applicants:

- If there is no insurance available through employment, provide a statement from your employer and/or your spouse's or parents' employer that the employer does not provide, offer or arrange for health insurance coverage or a group health plan for any of its employees. If you/your spouse/parent are self-employed, submit a statement on your business letterhead certifying that you/your spouse/parent operate your own business and do not provide any type of health insurance through this business.
- If you do not qualify for insurance because you are a part-time employee, provide a statement from your employer and/or your spouse's or parents' employer advising the average number of hours worked per week and the number of hours needed to qualify for coverage in the group's health insurance plan. In addition, have the employer submit a copy of the eligibility section from the group health insurance plan booklet.
- If you are currently insured, attach a copy of your policy. (Does not apply if you are currently insured under COBRA or State Continuation.)
- If you are eligible for Medicare due to disability or end-stage renal disease, please submit a copy of your Medicare Identification card. If you are eligible for Medicare due to age, you are not eligible for any of the CHIP programs.

For Plans 2 or 3 only:

- If you are applying for Plans 2 or 3, you must provide documentation that you have either been denied health insurance coverage within the past nine months or that you have one of the listed presumptive medical conditions as outlined in the summary of

coverage brochure. The notice of rejection must be on the insurance company's letterhead and must be signed by someone with underwriting authority. You must have been declined based on health or medical reasons. We will not accept trial applications, underwriting opinion forms, rescission letters, or rejections from insurance producers. A rejection notice must be issued as a result of a formal application for coverage. Physician statements must document your primary medical condition.

- As an alternative, if you have received notice from your current insurer that they will not renew your coverage except at a premium that exceeds the applicable CHIP rate that you or a member of your family is directly responsible for paying, provide a copy of your current health insurance policy as well as a copy of your most recent premium notice for this coverage.

For Plan 5 only:

If you are applying for Plan 5, submit a copy of the following documentation:

- Certificate of creditable coverage proving that you have had at least 18 months of creditable coverage without a break of more than 90 days at a time.
- Verification of the start and end dates of any COBRA or other continuation coverage.
- Termination letter or notice describing why and when your continuation coverage ended.
- Proof of final payment under COBRA through your last month of eligibility. Either a copy of your last COBRA premium notice and the front and back of your cancelled check or a statement from your former employer verifying that you are paid through your COBRA termination date will be sufficient.

Step 9. Important Information

Carefully read each paragraph and sign and date the application. Your signature verifies that you have read and understood the requirements for coverage.

Step 10. Mail the application and all documentation

If your application is incomplete or if we have any questions, we will contact you for additional information. We will also contact you once your application has been processed. You will be told whether your application has been accepted or denied.