



773 W. Lincoln Blvd., Suite 402, Freeport, IL 61032
 (815) 599-7050 or (800) 723-0202

FOR INTERNAL USE ONLY	
Eff Date	Group Number 6525

CONFIDENTIALITY NOTICE: When completed, this document contains confidential information which is legally privileged and intended only for the use of enrollment with Northern Illinois Health Plan. You are hereby notified that any reading, disclosure or distribution of the information on this form is strictly prohibited by applicable law.

NEW	CHANGE
<input type="checkbox"/> New Employee <input type="checkbox"/> COBRA <input type="checkbox"/> Other _____	<input type="checkbox"/> Add Newborn <input type="checkbox"/> Add Spouse Date of Marriage: _____ <input type="checkbox"/> Other _____ Date: _____

SECTION A: SUBSCRIBER INFORMATION

Employer Name Boone County	Location	Class	Telephone Number (Work) ()	Date of Hire	
Employee Last Name	First Name	Middle	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address		Social Security Number	<p align="center">WAIVER OF COVERAGE</p> <p>Please read and sign Section F only if you are declining Dental coverage through Northern Illinois Health Plan.</p>		
City	State	Zip			Telephone Number (Home) ()
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated		Covered by another plan in addition to this plan <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, name of other plan			

SECTION B: SPOUSE / DEPENDENT DATA (LIST PERSONS TO BE COVERED UNDER THE PLAN)

	Name (If last name is different from Applicant, please indicate name)	Date of Birth	Gender (M/F)	Social Security Number	Covered by another DENTAL Plan in addition to this plan? (If yes, complete the information in Section C)	Effective Date:
02	Spouse				<input type="checkbox"/> Yes <input type="checkbox"/> No Name of Plan:	
03	1st Child				<input type="checkbox"/> Yes <input type="checkbox"/> No Name of Plan:	
04	2nd Child				<input type="checkbox"/> Yes <input type="checkbox"/> No Name of Plan:	
05	3rd Child				<input type="checkbox"/> Yes <input type="checkbox"/> No Name of Plan:	
06	4th Child				<input type="checkbox"/> Yes <input type="checkbox"/> No Name of Plan:	

SECTION C: COORDINATION OF BENEFITS DATA

Is your spouse employed?*** <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your spouse retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are any members listed in Section A or B covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes to above, give name and address of employer:		If Yes, list names of dependents covered: _____ Policy or Medicare ID #: _____	
		Give the name and address of your spouse's insurance co.	Insurance Company Phone Number ()
		Give the name and address of your dependent's insurance co.	Insurance Company Phone Number ()
Employer's Phone Number ()	Department	Policy Number	Group Number Subscriber Number

SECTION D: DEPENDENT INFORMATION

- Are any of your adult dependents covered under other group health coverage through their or their spouse's employer? Yes No
If yes, which children? _____
- Are any of the dependents on your policy mentioned in a divorce decree or court order? Yes No
If no, please indicate which parent has custody of each dependent: _____
If Yes, We must have a copy of the divorce decree or court order to process any of your dependent's claims
- Does a divorce decree or court order make provisions as to which party is responsible for carrying insurance coverage for dependent children?
 Yes **If Yes, provide a COPY of the section of the divorce decree or court order relating to insurance.**
 No **If No, please indicate which child(ren) are not covered under a divorce decree or court order:** _____
- Do your child(ren) have a military status? Name: _____ Active Veteran
Name: _____ Active Veteran

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SECTION E: AUTHORIZATION

I request healthcare coverage under my employer's plan as it is now or as it may be amended in the future. I represent, to the best of my knowledge and belief, that all statements and answers made in this application are complete and true. I understand that fraud or other misrepresentation of information required in this application may result in loss of coverage. I hereby authorize my employer to make payroll deductions, if required, for the coverage selected. I authorize the release of my and/or my dependent's medical information necessary to process claims and to otherwise administer my coverage, such release to be made by my health care providers to Northern Illinois Health Plan personnel and by Northern Illinois Health Plan to other health care personnel as necessary. This authorization is valid for the term of coverage under the policy, or as otherwise required by Northern Illinois Health Plan to properly administer my coverage. I authorize payment of medical benefits to the provider or supplier for services submitted.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other dental insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within thirty (30) days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption.

I have read and understand this authorization. I realize that I am entitled to receive a copy of this authorization form.

Signature Of Employee

Date

SECTION F: WAIVER OF COVERAGE

You may decline health coverage offered by Boone County. This is called a waiver of coverage. If you waive coverage for yourself, you may not cover dependents under the Employer's health plan.

Note that after 2013, if you decline coverage considered affordable and minimum essential under the Patient Protection and Affordable Care Act ("ACA"), you will not qualify for government credits and subsidies to purchase individual health insurance on the Marketplace.

The decision to waive coverage has consequences for you. For example:

- You should be aware of the individual responsibility requirement taking effect in 2014 under the ACA. If you refuse the offer of the Employer's health coverage and do not obtain coverage on your own, you will be subject to a penalty.
- Unless you sign a waiver stating that you are covered under another plan, such as a spouse's plan, Medicaid, or Medicare, you cannot enroll in the Employer's health plan until the next open enrollment. However, if you are covered under another plan, but that coverage is lost, you can enroll in your Employer's health plan immediately. There's a time limit for enrolling after the other coverage is lost: you must request to enroll in your plan within 30 days of losing the other coverage.
- If you gain a new dependent through birth, adoption or marriage, you may enroll yourself, the new dependent, and the entire family at that time, but you must do so within 30 days of gaining the new dependent. If you miss the 30-day enrollment deadline, you must wait until open enrollment.

I acknowledge that the Employer has offered me affordable minimum essential coverage. I have read the above and I understand the consequences of my waiver of coverage.

Name of Employee

Signature of Employee

Date

As a representative of the Employer, I received this Waiver of Coverage from the above employee on _____ (Date).

Signature of the Employer Representative

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within thirty (30) days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption.

Signature of Employee

Date