All Kids Application Agents
Checklist and Technical Assistance Payment Request

FamilyCare
Moms & Babies

All Kids Application Agents: Complete the checklist.

- ☐ a. The application is signed and dated.
- ☐ b. All questions are answered.
- ☐ c. All pages of the application are attached, except for pages 9 and 10, which should be kept by the applicant.
- ☐ d. Social Security numbers are provided in question 4 for each person if they have one. If they do not have one and have applied for one, proof of application is attached. Otherwise the question is answered N/A.
- ☐ e. For question 7, proof of income for each month is attached if the income for this/these month(s) is different than the family's current income.
- ☐ f. If question 8 is answered “yes” for anyone, proof of pregnancy is included.
- ☐ g. If question 9 is answered “yes” for anyone, proof of U.S. Citizenship and identity is included.
- ☐ h. For question 10, Alien Registration Numbers and documentation are provided for each person if they have one.
- ☐ i. For question 11, if insurance has ended because the person met the lifetime limit, attach proof.
- ☐ j. Proof of income for all income reported in questions 15 and 16 is attached.
- ☐ k. Proof of child support or spousal support paid in question 17 is attached.
- ☐ l. The Rebate Form is completed and attached for families with insurance who would like All Kids/FamilyCare Rebate.

Applicant Name _____ Birth Date _____

Application Agent Name _____ ID # _____

Contact Person _____ Phone _____ Fax _____

Signature_____ Date _____

State of Illinois

Application

for All Kids, FamilyCare, and Moms & Babies Health Insurance

Nothing is more important than making sure your family has access to healthcare. Programs like these make that possible. Thank you for taking the time to complete this application. You can also apply online at www.allkids.com.

- **All Kids** covers children who need health insurance. Some families who pay for private health insurance for their children may qualify for help to pay their premiums.
- **FamilyCare** covers parents living with their children age 18 or younger. FamilyCare also covers grandparents or other relatives who are raising children in place of their parents. Some families who pay for private health insurance may qualify for help to pay their premiums.
- **Moms & Babies** covers pregnant women and their babies.

Apply now! Print in ink. Answer all the questions. If you need more space use an extra sheet of paper. If someone in your family already gets All Kids, FamilyCare or Moms & Babies, you do not need to file a new application. Call your customer service representative or caseworker.

Tell us about the applicant.

The applicant is usually the person filling out this form. The applicant should be the parent, guardian, or relative a child lives with, or a pregnant woman.

Applicant's name _____
Last First

Birth date __ __ / __ __ / __ __ __ __ (m m / d d / y y y y) **Social Security Number** __ __ __ - __ __ - __ __ __ __ Optional

Address _____ **Apt. #** _____

City _____ **State**_____ **Zip** _____ **County** _____

Phone (_____)_____, (_____) _____
Home Work

If you do not have a phone and we can reach you by calling someone else, tell us who.

Name _____, Phone ( ) _____

How many people live with you? _____ **How many of them want health insurance or help paying premiums?** _____

What language do you use the most? ☐ English ☐ Spanish ☐ Other _____

You can help us by answering the next two questions, but you do not have to tell us.

Are you of Hispanic or Latino origin? ☐ Yes ☐ No

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown (Mark **all** that apply.)

Tell us about the people who want health insurance or want help to pay premiums.

Be sure to list yourself if you want health insurance or want help to pay premiums.

Person #1	Person #2	Person #3
1. Name		
(Last, First)	(Last, First)	(Last, First)
2. Sex		
☐Male ☐Female	☐Male ☐Female	☐Male ☐Female
3. Birth date		
__ __/ __ __/ __ __ __ __ (mm/dd/yyyy)	__ __/ __ __/ __ __ __ __ (mm/dd/yyyy)	__ __/ __ __/ __ __ __ __ (mm/dd/yyyy)
4. Tell us the Social Security Number, if the person has one. If they applied for one, tell us the date. ✔ Send proof they applied. **For anyone else, write N/A.**		
__ __ __ - __ __ - __ __ __ __ ☐This person applied for a number on _____. (mm/dd/yyyy)	__ __ __ - __ __ - __ __ __ __ ☐This person applied for a number on _____. (mm/dd/yyyy)	__ __ __ - __ __ - __ __ __ __ ☐This person applied for a number on _____. (mm/dd/yyyy)
5. How is this person related to the applicant?		
☐Son ☐Daughter ☐Self ☐Spouse ☐Other: _____	☐Son ☐Daughter ☐Self ☐Spouse ☐Other: _____	☐Son ☐Daughter ☐Self ☐Spouse ☐Other: _____
6. Is this person an American Indian or Alaska Native?		
☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
7. Has this person received medical care in the past 3 months that you want us to pay for? If yes, tell us which months. ✔ Send proof of income for each month, if different from your current income.		
☐Yes ☐No 1. _____ 2. _____ 3. _____	☐Yes ☐No 1. _____ 2. _____ 3. _____	☐Yes ☐No 1. _____ 2. _____ 3. _____
8. Is this person pregnant or has this person been pregnant in the last 3 months? ✔ If yes, send a signed statement from a doctor or health clinic with the expected date of delivery and the number of the babies expected.		
☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Person #1	Person #2	Person #3
9. Is this person a U.S. citizen? If yes, tell us where they were born.		
☐Yes City : _____ State: _____ ☐No	☐Yes City: _____ State: _____ ☐No	☐Yes City: _____ State: _____ ☐No

✔ If yes, provide one of the following documents: U.S. Passport, Certificate of Naturalization (N-550 or N-570) or Certificate of Citizenship (N-560 or N-561).

If these are not available, provide one item from each column:

Place of birth –

- Certified copy of a birth certificate from the state or county where the person was born;
- Final Adoption Decree;
- Official military record that shows a place of birth;
- Papers showing the person was employed by the U.S. government before 1976.

Identity –

- Driver's license;
- State issued ID card;
- School ID;
- U.S. military ID;
- U.S. military dependent card; or
- Other government ID (city, county or U.S. state issued).
- For children under age 16:
  - School or day care records or a report card, OR
  - A parent or guardian's signature on page 7 of this application

Read page 9 for more information on how to get your birth certificate.

10. If this person has a valid Alien Registration Number, write it below and provide proof. Pregnant women and children who do not have an Alien Registration Number may still get health insurance.

✔ Send a copy of one of the items listed below as proof for each Alien Registration Number you list on this form.

- Alien Registration Receipt Card, Permanent Resident Card or Green Card
- Passport with the following stamps or attachments: Arrival-Departure Record (I-94) including the stamp showing status, Resident Alien Form (I-551) or Temporary Resident Card (I-688)
- A court-ordered notice for asylees
- Other proof of lawful immigration status

Receiving most public health benefits should not affect a person's immigration status. The U.S. Citizenship and Immigration Service may consider someone to be a public charge if they live in long-term care, like a nursing home or mental health facility that the government pays for.

Person #1	Person #2	Person #3
11. Has this person had health insurance or Medicare any time in the last 12 months? If yes, complete all of the following.		
☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Month, Day and Year Coverage Began __ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __
If the insurance ended, tell us the month, day and year it ended and why. __ __ / __ __ / __ __ __ __ ☐Someone's job ended ☐Met lifetime limit ☐Other: _____	__ __ / __ __ / __ __ __ __ ☐Someone's job ended ☐Met lifetime limit ☐Other: _____	__ __ / __ __ / __ __ __ __ ☐Someone's job ended ☐Met lifetime limit ☐Other: _____
Insurance Company		
Name of Policyholder		
Policyholder's SSN (optional) __ __ __ - __ __ - __ __ __ __	__ __ __ - __ __ - __ __ __ __	__ __ __ - __ __ - __ __ __ __
Employer Name		
Phone Number ( )	( )	( )
Policy Number		
Group Number		
Are both physician and hospital services covered? ☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Is this COBRA insurance? COBRA is group insurance you buy from a former job. ☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Relationship to policyholder		
If this person cannot use the insurance, tell us why.		

12. For anyone 18 or younger, we need their parents' names. You can help us by answering the other questions, but you do not have to tell us. **For anyone without this information, write N/A.**

Mother's full name: SSN: __ __ __-__ __-__ __ __ __ Employer: ☐Full-time ☐Part-time	**Mother's** full name: SSN: __ __ __-__ __-__ __ __ __ Employer: ☐Full-time ☐Part-time	**Mother's** full name: SSN: __ __ __-__ __-__ __ __ __ Employer: ☐Full-time ☐Part-time
Father's full name: SSN: __ __ __-__ __-__ __ __ __ Employer: ☐Full-time ☐Part-time	**Father's** full name: SSN: __ __ __-__ __-__ __ __ __ Employer: ☐Full-time ☐Part-time	**Father's** full name: SSN: __ __ __-__ __-__ __ __ __ Employer: ☐Full-time ☐Part-time

Person #1	Person #2	Person #3

13. For anyone who is married, tell us about their spouse. You can help us by answering these questions, but you do not have to tell us. **For anyone without this information, write N/A.**

Spouse's full name:	**Spouse's** full name:	**Spouse's** full name:
SSN: __ __ __-__ __-__ __ __ __	SSN: __ __ __-__ __-__ __ __ __	SSN: __ __ __-__ __-__ __ __ __
Employer:	Employer:	Employer:
☐Full-time ☐Part-time	☐Full-time ☐Part-time	☐Full-time ☐Part-time

Tell us about other people in your family and your income.

14. We need to know about your family group to decide if you can get health insurance.
Family group means people in your family who live with you. You, your spouse, any children 18 or younger and their parents, if they also live with you, make up your family group.

Tell us about anyone in your family group who is NOT asking for health insurance.

Name _____ SSN (optional) __ __ __-__ __-__ __ __ __
Birth date __ __/__ __/__ __ __ __ Relationship to applicant _____

Name _____ SSN (optional) __ __ __-__ __-__ __ __ __
Birth date __ __/__ __/__ __ __ __ Relationship to applicant _____

Name _____ SSN (optional) __ __ __-__ __-__ __ __ __
Birth date __ __/__ __/__ __ __ __ Relationship to applicant _____

15. Is any adult, parent, stepparent, spouse or pregnant woman named on this form currently employed? ☐Yes ☐No
Is anyone named on this form self-employed or own their own business? ☐Yes ☐No
If yes, complete the following. If you own your own business or are self-employed, enter "self" for employer.

✔ Send a copy of one pay stub (including tips) received in the last 30 days from each job.
If anyone is self-employed, provide 30 days of detailed business records that include income and expenses. For a sample form, visit www.allkids.com.

Name _____ Employer _____
Employer address _____ Phone (_____) _____
Number of hours worked weekly _____ Amount paid before taxes (include tips, bonuses, commissions) _____ How often paid _____

Name _____ Employer _____
Employer address _____ Phone (_____) _____
Number of hours worked weekly _____ Amount paid before taxes (include tips, bonuses, commissions) _____ How often paid _____

Name _____ Employer _____
Employer address _____ Phone (_____) _____
Number of hours worked weekly _____ Amount paid before taxes (include tips, bonuses, commissions) _____ How often paid _____

16. Is anyone named on this form GETTING money from any source other than employment (such as Social Security, child support, spousal support, rental property, unemployment benefits, pensions, trusts)? ☐Yes ☐No **If yes, tell us about them.**

✔ Send proof of one payment received in the last 30 days for each source of income you list.

Name _____ Source _____

Payment amount _____ How often paid _____

If this is rental property income, does the person receiving the income manage the property? ☐Yes ☐No

Name _____ Source _____

Payment amount _____ How often paid _____

If this is rental property income, does the person receiving the income manage the property? ☐Yes ☐No

Name _____ Source _____

Payment amount: _____ How often paid _____

If this is rental property income, does the person receiving the income manage the property? ☐Yes ☐No

17. Is anyone named on this form PAYING child support or spousal support? ☐Yes ☐No **If yes, tell us how much they paid in the last month.**

✔ Send proof of one payment made to each person in the last 30 days.

Name _____ Amount _____ How often paid _____

Name _____ Amount _____ How often paid _____

18. Is anyone named on this form PAYING for child care so they can work? ☐Yes ☐No **If yes, tell us how much they paid in the last month for each child.**

Name of child in child care _____ **Name** of care giver _____

Person paying for care _____ Payment amount _____

Relationship of care giver to child (if any) _____ How often paid_____

Name of child in child care _____ **Name** of care giver _____

Person paying for care _____ Payment amount _____

Relationship of care giver to child (if any) _____ How often paid_____

Name of child in child care _____ **Name** of care giver _____

Person paying for care _____ Payment amount _____

Relationship of care giver to child (if any) _____ How often paid_____

19. Please tell us how you heard about All Kids.

Check all the boxes that apply.

☐Radio ad
☐TV ad
☐Billboard
☐Newspaper ad or story
☐Mail sent to my home
☐Internet or Website
☐Doctor's office
☐Clinic
☐Hospital
☐Friend or relative
☐Employer
☐School
☐Government office or agency
☐W.I.C. site
☐Labor union
☐Other: _____

Read and sign.

Read carefully, then sign and date the application below.

1. We will keep what you tell us private as required by law.
2. Some families have to make a payment each month for this health insurance. This payment is called a premium. The amount of the premium depends on the family's income.
3. Some families have to pay part of the bill when they visit the doctor, go into the hospital or get a prescription filled. These payments are called co-payments. The amount of co-payment depends on the family's income.
4. You agree the state may seek reimbursement for services the state covered for your family if those services should have been paid for by any other health coverage your family may have.
5. Be sure to answer the questions correctly. We may check all information on this form. You must help us if we ask you to prove that your information is right.
6. We will **not** share any information about immigration of any person who does not have an Alien Registration Number. We **will** verify the immigration status of any person if you gave us their Alien Registration Number. To do that, we will check the number with the U.S. Citizenship and Immigration Service (USCIS). We may send other information to USCIS, such as copies of proof you sent of an Alien Registration Number and the person's Social Security Number, if they have one.
7. You must tell your All Kids or FamilyCare representative within 10 days if any of the following happens:
   - Your income changes.
   - The number of people in your family who live with you changes.
   - Your address or phone number changes.
   - Someone who gets health benefits moves out of Illinois, dies, or goes to jail or prison.
8. If we pay medical bills for you, you give your right to collect medical support payments to the State of Illinois. You must help us if we ask you to establish paternity or obtain medical support payments for members of your family. You may not have to do this if you have a good reason not to. Your children can get health insurance even if you do not help us when we ask you to help.
9. Anyone who misuses our health insurance card may be committing a crime.

I declare under penalty of perjury that I have read all statements on this form and the information I give is true, correct and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information.

Applicant's signature _____ Date _____
(Make a mark and have another adult sign next to your mark if you cannot sign your name.)

If you completed this application on behalf of the Applicant, sign and complete the following.

Signature _____ Date _____ Phone (____)_____

Name (print) _____ Relationship to applicant _____

Need help? Visit www.allkids.com or call toll-free: 1-866-All-Kids (1-866-255-5437).
If you use a TTY, call 1-877-204-1012.

Final checklist

- Did you answer all the questions on the application?
- Did you sign and date the application?
- Do you have copies of all the proofs we said you would need? All the information that needs proof is marked with a ✔ .
- If you want to apply for rebates, did you get both sides of the Rebate Form completed and signed?

Mail your application along with copies of any proof to:

All Kids Unit
P. O. Box 19122
Springfield, IL 62794-9122

If you use the envelope that came with this application, you do not need to use a stamp.

Next steps

- If any information changes after you send the application, call toll-free 1-866-All-Kids (1-866-255-5437) to tell us what changed. If you use a TTY, call 1-877-204-1012.
- We will review your application as quickly as possible.
- If we find something is missing, we will send you a letter telling you what else to send.
- Please allow 45 days for us to make a decision.
- We will send you a notice to tell you if you can get All Kids, FamilyCare or Moms & Babies. If you do not qualify, we will also send a notice and tell you why.

Other important information

● If your children already have an All Kids card, do not apply again. If you want to add someone to your All Kids, FamilyCare or Moms & Babies health plan, you do not have to send a new application. Call your caseworker at the Illinois Department of Human Services (DHS) or call your All Kids customer service representative to add another family member.

● If your family has child support or Social Security income, a stepparent in the home, high medical bills, or you are applying for a disabled family member or one who is 65 or older, it may be better for you to apply at your DHS Family Community Resource Center. For more information, call toll-free 1-866-All-Kids (1-866-255-5437). If you use a TTY, call 1-877-204-1012.

● If you are not satisfied with the actions taken on your application, you have the right to a fair hearing. You can ask for a fair hearing by writing your local office, or by writing the Department at Bureau of Administrative Hearings, 401 South Clinton Street, Sixth Floor, Chicago, Illinois 60607 or by calling 1-800-435-0774. If you use a TTY, call 1-877-734-7429. **Use these numbers only to file an appeal.** All other calls and inquiries should be directed to 1-866-All-Kids (1-866-255-5437). If you use a TTY, call 1-877-204-1012.

● All Kids, FamilyCare and Moms & Babies are open and accessible without regard to sex, race, disability, national origin, religion or age. The State of Illinois is an equal opportunity employer that practices affirmative action. The State of Illinois provides reasonable accommodations according to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

U.S. citizenship documents

Because of a new federal law, we must ask people who are United States citizens to send us documents that prove they are citizens. This new law affects all children and adults who apply for medical benefits if they are U.S. citizens.

If you do not have these documents for anyone in your family who is a U.S. citizen, you must try to get them.

You can get birth certificates from the state or county where the person was born. You may have to pay for official copies of birth certificates. Usually, you need to know the person's name, date of birth and parents' names to order their birth certificate.

- Persons who were born in Illinois can get their birth certificate from the county where they were born. Here are a few county phone numbers and websites:

County	Phone	Website
Champaign	1-217-384-3720	www.champaigncountyclerk.com/vitals
Cook	1-312-603-7799	www.cookctyclerk.com
DuPage	1-630-682-7035	www.co.dupage.il.us
Jackson	1-618-687-7360	www.co.jackson.il.us/elected/co_clerk.htm
Kane	1-630-232-5950	www.co.kane.il.us/coc
Lake	1-847-377-2411	www.co.lake.il.us/cntyclk/vital
Peoria	1-309-672-6059	www.co.peoria.il.us (Select "Get Vital Records")
Rock Island	1-309-786-4451	www.co.rock-island.il.us
St. Clair	1-618-277-6600	www.co.st-clair.il.us (Select "B")
Will	1-815-740-4615	www.willclrk.com/vitalrecords.htm

You can get a complete list of where to go for a birth certificate for any county in Illinois on the Internet at **www.idph.state.il.us/vitalrecords/countylisting.htm**. The Illinois Department of Public Health can help you find a county office if you call **1-217-782-6553**. If you use a TTY, call 1-800-547-0466. The call is free.

- Persons who were born in Illinois can also get birth certificates from the Illinois Department of Public Health by calling **1-217-782-6553**. You can order your birth certificate over the Internet at **www.idph.state.il.us/vitalrecords** if you use a credit card.

- The National Center for Health Statistics can help you find out where to get birth certificates for people who were born in a state other than Illinois. Call **1-866-441-6247**. The call is free. If you can use a computer, visit **www.cdc.gov/nchs**.

If you cannot get these documents, call 1-866-All-Kids to tell us why. If you use a TTY, call 1-877-204-1012. The call is free. There may be other documents that you can use to show that you or your family member is a U.S. citizen.

Other benefit programs offered by the State of Illinois

Veterans Care offers access to affordable, comprehensive healthcare to veterans across Illinois. Veterans pay an affordable monthly premium of $40 or $70 and receive medical, dental and vision coverage. For additional information, please visit www.illinoisveteranscare.com or call 1-877-4VETS-RX. If you use a TTY, call 1-877-204-1012.

Illinois Cares Rx provides a safety net for seniors and persons with disabilities so they won't have to pay more out of pocket under the Medicare drug plan. To find out more, visit www.illinoiscaresrx.com or call the Illinois Health Benefits hotline at 1-800-226-0768. If you use a TTY, call 1-877-204-1012.

The **Illinois Rx Buying Club** provides an average discount of 24% at many Illinois pharmacies. To get more information or to enroll visit www.illinoisrxbuyingclub.com or call 1-866-215-3462. If you use a TTY, call 1-866-215-3479.

Health Benefits for Workers with Disabilities is a comprehensive healthcare program for employed persons with disabilities. Working individuals between the ages of 16 and 64 may be eligible. To download an application, visit www.hbwdillinois.com or call 1-800-226-0768. If you use a TTY, call 1-866-675-8440.

HFS Medical Benefits provides comprehensive healthcare for low-income seniors and persons of any age with disabilities. To apply, visit a local Department of Human Services office. To find an office nearby, call 1-800-843-6154. If you use a TTY, call 1-800-447-6404. You can download a mail-in application by visiting www.health.illinois.gov.

The **Low Income Home Energy Assistance Program (LIHEAP)** helps qualified households pay for winter energy services. The amount of the benefit depends on income, household size, fuel type and geographic location. Visit www.liheapillinois.com/community.html.

The **Illinois Department of Human Services' Child Care Program** provides low-income, working families with access to quality, affordable child care. Parents can learn about child care in their community and see if they qualify for a subsidy by contacting their local Child Care Resource and Referral agency (CCR&R). Visit www.ilchildcare.org or call 1-800-649-1884 to find your local CCR&R.

The **HFS Division of Child Support Enforcement (DCSE)** will help anyone who needs support for a child. DCSE helps parents and caretakers locate the parent who does not live with the child, legally establish the child's father, get child support or medical coverage and change the amount a parent has to pay for child support. Services are free. You can apply for services by visiting www.ilchildsupport.com, by calling 1-800-447-4278 or by visiting a DCSE office. If you use a TTY, call 1-800-526-5812. The call is free.

If you are interested in registering to vote, please go to www.elections.il.gov/ or call the Department of Human Services Helpline at 1-800-843-6154 or 1-800-447-6404 (for TTY). If you would like assistance or need translation services, please contact your DHS Family Community Resource Center.

Rebate Form for All Kids and FamilyCare

Use this form if you want All Kids or FamilyCare Rebate.

A rebate is a monthly amount we will pay you if you already pay for health insurance for yourself, your spouse or your children. If you choose to get rebates, you will use your current insurance card to get healthcare.

Only families who have health insurance can get rebate payments. Also, only families with a certain amount of income can get rebates. You may be able to get rebates for your children if your family is like one in the list below. The income amounts for adults are lower.

☐ You are the **only** person in your family	→	You may qualify for rebates if the income you get each month is between $1,201 and $1,805.
☐ You have **two** people in your family	→	You may qualify for rebates if the income you get each month is between $1,616 and $2,428.
☐ You have **three** people in your family	→	You may qualify for rebates if the income you get each month is between $2,030 and $3,052.
☐ You have **four** people in your family	→	You may qualify for rebates if the income you get each month is between $2,445 and $3,675.

Add $623.00 for each additional person.

To ask for rebates, you must send this form **with** the rest of your application.

Part A

The main person whose name is on the insurance must sign this part of the form. Often this person is called the policyholder. This person may get the health insurance from a job.

Policyholder's name _____
Last First

Home Address _____ **Apt. #** _____

City _____ **State** _____ **Zip** _____

SSN __ __ __ - __ __ - __ __ __ __ **Phone** (_____) _____

We must have the SSN (Social Security Number) so we can pay the rebate to this person.

Policy Number _____ **Group Number** _____

Tell us the names of the family members you want rebates for.

_____

_____

I agree to call All Kids/FamilyCare right away if this health insurance ends, someone is added or taken off the health insurance, the amount paid for the insurance changes, covered benefits change or someone else becomes the policyholder.

I authorize my employer, plan administrator and insurance company to provide the information requested in Part B on the next page for the purpose of determining whether I qualify for All Kids/FamilyCare. I also authorize my employer, plan administrator and insurance company to verify my coverage and any of the information below for any time when I get All Kids/ FamilyCare Rebate.

Signature of Employee/Policyholder _____

Part B

This part of the form must be completed by the employer providing the health insurance or the insurance agent.

Note to Employer/Insurance Agent: The employee/policyholder named on the front of this form is applying for help to cover the cost of their family's health insurance premiums. Please assist them by completing the information below and returning the form to the employee/policyholder as soon as possible. (As used below, "employee" applies to an employee or private policyholder.) For help in completing this form, call toll-free 1-877-805-5312.

Employer (if employer policy) _____

Employer address _____

City _____ **State** _____ **Zip** _____

Person completing this form _____

Phone (_____) _____ **Fax** (_____) _____

Insurance company _____ **Policy Number** _____ **Group Number** _____

What benefits are covered? ☐Physician Services ☐Hospital Inpatient Services
Check all that apply.

Amount of premium paid by employee $_____
Include amounts paid for dental, vision and prescription coverage.

Premiums are paid ☐weekly ☐every 2 weeks ☐twice a month ☐monthly
☐every 2 months ☐quarterly ☐semi-annually ☐annually

Persons covered by the employee premium contribution:

_____

_____

Does the employer pay 100% of the cost of the employee's coverage? ☐Yes ☐No
If no, how much of the amount listed above is for coverage of the employee only (single rate)?

$_____ Include amounts for dental, vision and prescription coverage.

Enrollment period for policy _____

Date the premium listed above began or begins _____

Date of next scheduled change in premium _____

Authorized signature of employer/agent _____ **Date** _____

Return the completed rebate form to the employee for submission with the All Kids / FamilyCare application.

Need help? Visit www.allkids.com or call toll-free: 1-866-All-Kids (1-866-255-5437).
If you use a TTY, call 1-877-204-1012.

State of Illinois

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R(5/09)

Part B

This part of the form must be completed by the employer providing the health insurance or the insurance agent.

Note to Employer/Insurance Agent: The employee/policyholder named on the front of this form is applying for help to cover the cost of their family's health insurance premiums. Please assist them by completing the information below and returning the form to the employee/policyholder as soon as possible. (As used below, "employee" applies to an employee or private policyholder.) For help in completing this form, call toll-free 1-877-805-5312.

Employer (if employer policy) _____

Employer address _____

City _____ **State** _____ **Zip** _____

Person completing this form _____

Phone (_____) _____ **Fax** (_____) _____

Insurance company _____ **Policy Number** _____ **Group Number** _____

What benefits are covered? ☐Physician Services ☐Hospital Inpatient Services
Check all that apply.

Amount of premium paid by employee $_____
Include amounts paid for dental, vision and prescription coverage.

Premiums are paid ☐weekly ☐every 2 weeks ☐twice a month ☐monthly
☐every 2 months ☐quarterly ☐semi-annually ☐annually

Persons covered by the employee premium contribution:

_____

_____

Does the employer pay 100% of the cost of the employee's coverage? ☐Yes ☐No
If no, how much of the amount listed above is for coverage of the employee only (single rate)?

$_____ Include amounts for dental, vision and prescription coverage.

Enrollment period for policy _____

Date the premium listed above began or begins _____

Date of next scheduled change in premium _____

Authorized signature of employer/agent _____ **Date** _____

Return the completed rebate form to the employee for submission with the All Kids / FamilyCare application.

Need help? Visit www.allkids.com or call toll-free: 1-866-All-Kids (1-866-255-5437).
If you use a TTY, call 1-877-204-1012.

State of Illinois

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