



Group Health Insurance Plans  
Employee's Acknowledgment of Eligibility Requirements  
Return with the completed Application Form

I hereby acknowledge that I am employed by

\_\_\_\_\_ (Name of Physician/s, or Name of the Medical Practice)

as of \_\_\_\_\_, 20\_\_\_\_\_, that I am regularly scheduled to work a minimum of **30 hours per week** (20 hours a week for the Dental plan only), and I am actively at work on the permanent payroll of the above named physician(s). I am aware that I must notify my employer or the Lake County Medical Society (LCMS) **in writing** of any change to my **name** or **home address** in order to receive timely notices concerning these insurance plans. I also understand that a **change in my family status** (births, marriage, divorce, loss of other coverage, adoption or placement for adoption) is a qualifying event that might change the eligibility of my dependents to enroll in this health plan. I will notify my employer and/or the plan administrator in writing within ten days following a change in family status or employment.

**I understand that my employer or I must report within ten days to Lake County Medical Society in writing if I retire or I am on disability, leave of absence, temporary layoff or if my employment terminates for any reason.** I understand that insurance continuation coverage may be available for me and my covered dependents (if any) for a limited period of time in accordance with the LCMS policy and applicable laws.

This information is given to the best of my knowledge and belief and is complete and true. I satisfy the eligibility requirements as described above on the date I am signing this application and no material information has been withheld or omitted. All the information given may become part of any application for enrollment in the group health and/or dental insurance plan of the LCMS, underwritten by Blue Cross Blue Shield of Illinois.

Employee's Name (Please Print) \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

Address \_\_\_\_\_ City/Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

This form must be returned to the **Lake County Medical Society**, 810 S. Waukegan Rd., Ste. 104, Lake Forest, IL 60045, along with the employee's **signed application** for enrollment in the group medical or dental insurance plan. You may fax to 847-574-0445. **Any information provided herein that is knowingly false is subject to penalties under the Illinois Health Benefits Fraud Act.** Our email address is LakeDocs@aol.com