

- OFFICE USE ONLY -

Idaho Small Employer Application

POLICY NUMBER	POLICY EFF DATE

Type of Enrollment:
 New Applicant
 Adding Dependents

Requested effective date:

 (Pursuant to terms of the contract)

Change current enrollment because of the following event:
 Marriage Divorce Birth
 Death Adoption
 Court Order (copy of court order required)
 Other: _____

Date event occurred: _____
 MM DD YYYY

Please type or print legibly in black ink and complete all applicable sections. Thank You.

EMPLOYER INFORMATION

Employer	Group No.
Address City State Zip	Phone No.

EMPLOYEE INFORMATION

Employee	Occupation	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other: _____
Address City State Zip	Phone No.	

Date of Full-Time Employment MM DD YYYY	Number of Hours Worked Per Week	Is your employer contributing toward this coverage?	Current Status: <input type="checkbox"/> At Work <input type="checkbox"/> COBRA <input type="checkbox"/> Disability <input type="checkbox"/> Other
--	---------------------------------	---	--

List all family members you wish to enroll, including any unmarried child who is under age 25 years and who receives more than one-half (1/2) of his financial support from the parent or an unmarried child of any age who is medically certified as disabled and dependent upon the parent (copy of certification required).

Self and Dependent's Names (First, Initial, Last)	Relationship to Applicant	Date of Birth	Sex	Weight	Height	Social Security Number
Applicant / Insured	Self					
Spouse						
Child						
Child						
Child						
Child						

Are you enrolling every eligible dependent? Yes No Complete the waiver section on page 3 of this application for any family members that are not to be insured.

CURRENT / PRIOR COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health insurance coverage (including Medicare or Medicaid) in effect within 12 months prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health insurance coverage was in effect within the past 12 months, please indicate NONE. If you have had coverage with another carrier within 63 days (excluding employee's probationary period) of this request a "Certificate of Health Plan Coverage" or proof of existing coverage must be provided to accurately credit your waiting periods.

Applicant's Name	Insurance Carrier (Policy # and Phone #)	Dates of Coverage (MONTH / DAY / YEAR)		Will continue any current coverage?	Type of Coverage		For Office Use Only
		FROM	TO		Group Dental	Individual Medical	
Employee		MM/DD/YY	MM/DD/YY	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Dental	<input type="checkbox"/> Individual <input type="checkbox"/> Medical	
Spouse				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Dental	<input type="checkbox"/> Individual <input type="checkbox"/> Medical	
Child				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Dental	<input type="checkbox"/> Individual <input type="checkbox"/> Medical	
Child				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Dental	<input type="checkbox"/> Individual <input type="checkbox"/> Medical	
Child				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Dental	<input type="checkbox"/> Individual <input type="checkbox"/> Medical	
Child				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Dental	<input type="checkbox"/> Individual <input type="checkbox"/> Medical	

If your coverage is terminated, please state reason: _____



HEALTH STATEMENT

INSTRUCTIONS:

- 1.) Each medical question below applies to all persons listed on this application who desire coverage.
- 2.) The questions apply to both past and present symptoms, conditions, diseases, illnesses, accidental injuries, or deformities (health conditions).
- 3.) Answer the questions below either Yes or No. Each of the questions must be answered. Answer Yes to a question if you or any family member for whom you want to obtain coverage now has, or at any time in the past has experienced or received care for the health condition or event specified in that question.
- 4.) Answer each question accurately and explain any conditions you answered yes to in the boxes provided below.
- 5.) Do not leave any question unmarked.
- 6.) No agent or any other person can waive these requirements or is authorized to set forth anything less than a complete and accurate response to each of the questions. The Insurance Carrier shall not be bound by an attempted waiver of complete answers to the questions set forth below.
- 7.) If you learn at any time before approval of coverage by the Insurance Carrier that any answer on this application is incomplete, you must advise the Insurance Carrier.

	Yes	No		Yes	No		Yes	No
1. Are you, your spouse, any eligible dependent child, or mate, whether or not listed on this application, now pregnant? ... Due Date _____	<input type="checkbox"/>	<input type="checkbox"/>	14. Bodily deformity or congenital disease/defect	<input type="checkbox"/>	<input type="checkbox"/>	31. Lung conditions or emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>
Complications anticipated?	<input type="checkbox"/>	<input type="checkbox"/>	15. Breast condition or fibrocystic breast disease	<input type="checkbox"/>	<input type="checkbox"/>	32. Lupus.....	<input type="checkbox"/>	<input type="checkbox"/>
Prior or anticipated multiple births?.....	<input type="checkbox"/>	<input type="checkbox"/>	16. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	33. Melanoma	<input type="checkbox"/>	<input type="checkbox"/>
2. Used any medication or drug within the past 12 months? (list below)	<input type="checkbox"/>	<input type="checkbox"/>	17. Colon / Bowel / Rectal condition	<input type="checkbox"/>	<input type="checkbox"/>	34. Mental or nervous conditions	<input type="checkbox"/>	<input type="checkbox"/>
3. Positive test for HIV (Human Immunodeficiency Virus) infection... ..	<input type="checkbox"/>	<input type="checkbox"/>	18. Depression	<input type="checkbox"/>	<input type="checkbox"/>	35. Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>
4. Acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC) ..	<input type="checkbox"/>	<input type="checkbox"/>	19. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	36. Neurological conditions	<input type="checkbox"/>	<input type="checkbox"/>
5. Alcoholism, drinking problem, drug abuse, or convicted of DUI/DWI	<input type="checkbox"/>	<input type="checkbox"/>	20. Disorders of the female reproductive organs/Infertility	<input type="checkbox"/>	<input type="checkbox"/>	37. Phlebitis / Blood clot	<input type="checkbox"/>	<input type="checkbox"/>
6. Allergies or Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	21. Disorders of the male reproductive organs including the prostate/infertility	<input type="checkbox"/>	<input type="checkbox"/>	38. Polio	<input type="checkbox"/>	<input type="checkbox"/>
7. Anemia or blood condition	<input type="checkbox"/>	<input type="checkbox"/>	22. Dizziness or headaches	<input type="checkbox"/>	<input type="checkbox"/>	39. Sinus conditions	<input type="checkbox"/>	<input type="checkbox"/>
8. Arthritis or rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	23. Epilepsy or seizure condition	<input type="checkbox"/>	<input type="checkbox"/>	40. Stomach conditions or ulcers	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list type			24. Eye, ear, nose or throat condition	<input type="checkbox"/>	<input type="checkbox"/>	41. Stroke or paralysis	<input type="checkbox"/>	<input type="checkbox"/>
9. Asthma or chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	25. Gallstone or gall bladder condition	<input type="checkbox"/>	<input type="checkbox"/>	42. Thyroid or pituitary conditions	<input type="checkbox"/>	<input type="checkbox"/>
10. Attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>	26. Heart or cardiovascular condition	<input type="checkbox"/>	<input type="checkbox"/>	43. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
11. Back or joint condition	<input type="checkbox"/>	<input type="checkbox"/>	27. Hernia or rupture	<input type="checkbox"/>	<input type="checkbox"/>	44. Tumor, growth, or cyst	<input type="checkbox"/>	<input type="checkbox"/>
If yes, pins in place?			28. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	45. Ulcerative colitis or Crohn's Disease ..	<input type="checkbox"/>	<input type="checkbox"/>
			If yes, last reading and date			46. Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
12. Bladder or kidney condition	<input type="checkbox"/>	<input type="checkbox"/>	29. High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	47. Any other condition or treatment in the last 5 years	<input type="checkbox"/>	<input type="checkbox"/>
13. Bone infection	<input type="checkbox"/>	<input type="checkbox"/>	If yes, last reading and date					
			30. Liver conditions, cirrhosis or hepatitis .	<input type="checkbox"/>	<input type="checkbox"/>	Other Information		
			If yes, list type			48. Are you a U.S. Citizen?	<input type="checkbox"/>	<input type="checkbox"/>
						49. Are you a resident of the state of Idaho?	<input type="checkbox"/>	<input type="checkbox"/>
						years _____ months _____	<input type="checkbox"/>	<input type="checkbox"/>
						50. Do you have a family doctor?	<input type="checkbox"/>	<input type="checkbox"/>
						Name _____		

If you answered Yes to any questions above, please explain below. Use extra paper if necessary.

Item No.	Patient's Name	Diagnosis / Condition Type of Treatment	Physician's Name and Address	Date of Illness	Date of Last Visit	Was Recovery Complete?

List any medications or drugs taken by all applicants within the past 12 months. Use extra paper if necessary.

Item No.	Patient's Name	Medication Name	Prescribing Physician and Address	Condition Requiring Medication	Still Taking?



Are you or any of your dependents currently disabled? Yes No

Name of Disabled Person

Physician's Name and Phone Number

Date of Disability

Physician's Address (street, city, state, and zip code)

Nature of Disability

Has any person listed on this application used tobacco during the past twelve (12) months? Yes No

If yes, list applicant's name(s): _____

Has surgery, diagnostic testing, medical treatment or follow-up visit been advised (but not yet performed) for any person listed on this application? Yes No

If Yes, give person's name and details: _____

Has any named person incurred medical expenses or claims exceeding \$10,000 in the past 24 months?..... Yes No

If Yes, give person's name and details: _____

Are you or any family members listed on this application covered on Medicare or have received Social Security Disability or Workers' Compensation payments or are now eligible to receive such payments? Yes No

If Yes, give person's name and details: _____

Has any insurance carrier refused, restricted (including waiver or condition), or rated any health coverage for you or any dependents listed on this application? Yes No

If Yes, please explain (list applicant's name, medical condition and whether refusal, waiver, or restriction): _____

Name of Insurance Carrier: _____ Date of refusal, etc.: _____

WAIVER OF COVERAGE

To be completed only if coverage is declined or refused by an eligible employee or dependents:

I waive all coverage for myself and dependents

I waive medical coverage for (check one):

Myself (and dependents, if any).

My dependent spouse only

My eligible dependent spouse and children only

My dependent children only

Other (Name) _____

Reason for declining coverage (check one):

Other group coverage through my spouse's employment.

Other individual coverage.

Other (please explain) _____

I have been given the opportunity to apply for group coverage as offered by the employer and, after careful consideration, have decided to waive coverage as indicated above. Should I decide to apply for this coverage in the future, I realize and agree any coverage may be subject to additional waiting periods. **Notice of enrollment rights:** 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 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 60 days after the marriage, birth, adoption, or placement for adoption.



AFFIRMATION

I affirm the answers given in this "Idaho Small Employer Application" are complete and correct. I am providing these answers as part of the application procedure required by this insurance carrier to enroll in its insurance coverage. I understand that the insurance carrier will rely on each answer in making its rating determination. I understand if this application contains any material misstatements or omissions, the insurance carrier may, within the first 24 months of coverage, deny coverage retroactively and / or take any other legal action available by law. I will promptly inform the insurance carrier in writing if anything happens before my coverage takes effect that makes any answer in the "Idaho Small Employer Application" incomplete or incorrect. I understand that a twelve month waiting period for coverage of pre-existing conditions may apply. I understand and agree no coverage shall be in force until approved by the insurance carrier. Coverage will be in force as of the effective date pursuant to the terms of the plan / contract.

STATEMENT OF UNDERSTANDING

By signing this application, I represent that all my answers are complete and accurate and that I understand and agree to the following conditions:

- No independent producer, agent or employee of the insurance carrier, or of my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The insurance carrier may terminate or rescind an employer's group coverage for any misrepresentation, omission of fact by, concerning, or on behalf of any applicant that was or would have been material to the insurance carrier's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim.
- As proof of status of employment, I authorize my employer to release to the insurance carrier appropriate documents, including but not limited to W-2 Wage and Tax Statements and other wage and tax summaries or forms.
- Coverage for me and any eligible persons named on this application will begin on the effective date pursuant to the terms of the plan / contract.
- The group's master policy is the document that sets forth all the terms and conditions of my coverage. No agent or other person can change the terms of the master contract, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of the insurance carrier.
- I understand that this application will become part of the contract between the insurance carrier and my employer.
- **I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.**
- NOTE: A pre-existing condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the enrollment date. A pregnancy existing on the enrollment date is not a preexisting condition under this policy. Genetic information shall not be considered as a preexisting condition in the absence of a diagnosis of the condition related to such information. The maximum preexisting condition period or late enrollee wait period is 12 months.

ACKNOWLEDGEMENT

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the enrollment form) for the purpose of facilitating health-care treatment, payment or for the purpose of business operations necessary to administer health-care benefits; or as required by law.

Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health-care practitioner;
- A clinic, hospital, long-term care or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or;
- An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

Signature of Employee _____ Date _____

Signature of Spouse _____ Date _____

