SIHO INSURANCE SERVICES
417 Washington Street
Columbus, IN 47201
800-443-2980

INSURANCE APPLICATION
EMPLOYEE ENROLLMENT FORM

GROUP #: _____

1. REASON FOR COMPLETING THIS FORM

I am a: ❑ New Employee
❑ Current Employee
❑ Late Enrollee

This form is completed in order to officially:
❑ Apply as New Enrollee
❑ Add Dependents
❑ Waive/Decline Coverage

DATE TO BE EFFECTIVE: Month _____ Day_____ Year _____

2. PERSONAL INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____State _____ Zip _____

Home Phone _____ Work Phone _____

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Company Name/Employer _____

Job Title _____ Date of Hire _____ Annual Salary $_____

Weekly Hours Worked: ❑ Less than 20 ❑ Between 20 and 30 ❑ Over 30 ❑ 40 Hours and Over

Employment Status: ❑ Active ❑ COBRA COBRA Expiration Date: _____ / _____ / _____

3. PLAN SECTION

Health Plan that you selected:

Prime Care Choice Plan:
❑ Choice 250 ❑ Choice 500 ❑ Choice 750 ❑ Choice 1000 ❑ Choice 2500

SIHO BasicCare:
❑ $500 Ded. Plan ❑ $1000 Ded. Plan ❑ $2500 Ded. Plan

SIHO Select Savings:
❑ HDHP $1000 ❑ HDHP $2500 ❑ SDHP $250 ❑ SDHP $500 ❑ SDHP $750

Enrollment Status for which you are Applying/Enrolling (please choose one)

❑ Employee ONLY ❑ Employee & Spouse ❑ Employee & Children ❑ Family ❑ LIFE Only (please complete section 4 and 5)

Please complete the table below for each person that will be covered.

	Last Name	First Name	Social Security #	Birth Date	Sex F/M	Height	Weight	Relation to Employee*	Primary Care Physician	Full-time Student Y/N
01 Self										
02 Spouse										
03 Child										
04 Child										
05 Child										
06 Child										
07 Child										

(* D = Dependent; SC = Step Child, please provide documentations)

3. PLAN SECTION (continued)

Are you currently active at work on a full-time basis? ❑ Yes ❑ No

Are you currently covered under Employer's Plan? ❑ Yes ❑ No
If yes, please attach Certificate of Credible Coverage.

If your spouse is to be covered, please complete the following information: Is your spouse employed? ❑ Yes ❑ No

If yes, Employer: _____ Spouse's name: _____

Will you or any member of your family be covered under OTHER health or medical insurance by divorce decree or any other reason? ❑ Yes ❑ No

If yes, who will be covered? ❑ 01Self ❑ 02 Spouse ❑ 03 Child ❑ 04 Child
❑ 05 Child ❑ 06 Child ❑ 07 Child

OTHER Insurance Company Name or Plan: _____

Address: _____

Policy # (should be listed on card): _____ Effective Date: _____

4. LIFE INSURANCE INFORMATION

Beneficiary Last Name	Beneficiary First Name	Beneficiary Social Security #	Date of Birth	Relationship
PRIMARY				
SECONDARY				

5. MEDICAL WAIVER SECTION

Complete this Section **ONLY** if you are Waiving (declining) the health coverage available to you through your employer. If you are choosing **NOT** to enroll, **COMPLETE THIS SECTION**. If your employer pays 100% of the employee cost of this health care coverage, you must enroll in this Health Plan for the employer to be considered eligible.

WAIVER: This is to acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through the employer named in Section 2. I hereby waive the health coverage offered. I am waiving the health coverage and declining to enroll because : *(form will be incomplete if selection is not marked)*

❑ Spousal Coverage
❑ Individual Health Coverage
❑ Coverage Under Another Plan
❑ Medicare, Medicaid, or Medical Supplement Coverage

❑ Other: _____

(if waiving, you MUST check/complete one of the above)

I attest that I was not pressured nor forced by the employer named in Section 2, the writing agent, SIHO, or any other outside party who might have a vested interest in my waiving (declining) the above noted coverage. I further realize that any future application for coverage under this plan may require additional limitations, waiting periods, or other applicable terms and conditions of a master group contract that would impact my benefits. I also understand that I may be asked to supply additional statements of health for any future enrollment. I freely and voluntarily waive (decline) the above noted coverage.

Employee Signature: _____ **Date:** _____

Please make sure Section #1 and #2 are completed and read even if you waive or decline coverage.

6. STATEMENT OF HEALTH STATUS FOR INDIVIDUALS TO BE COVERED

Check all medical conditions/disease listed below for which you or any of your dependents have been diagnosed, treated or counseled within the past 3 years: (Use number and letter to identify conditions in Section 8)

❑ 1. Transplant	❑ 18. Asthma	❑ 35. Heart Surgery
❑ 2. AIDS/AIDS Related Complex	❑ 19. Paralysis	❑ 36. Congestive Heart Failure
❑ 3. Arthritis	❑ 20. Multiple Sclerosis	❑ 37. Pacemaker
❑ 4. Rheumatoid Arthritis	❑ 21. Cerebral Palsy	❑ 38. Ischemic Heart Disease
❑ 5. Thyroid Disease	❑ 22. Epilepsy	❑ 39. High Blood Pressure
❑ 6. Spina Bifida	❑ 23. Parkinson's Disease	❑ 40. Currently Pregnant If so, state expected date: _____ /_____ /_____
❑ 7. Ulcerative Colitis	❑ 24. Alzheimer's Disease	
❑ 8. Diverticulitis	❑ 25. Hemophilia	
❑ 9. Crohn's Disease	❑ 26. Juvenile Diabetes	❑ 41. Alcohol or Drug Dependency
❑ 10. Gastric / Peptic Ulcer	❑ 27. Diabetes Insulin Dependent	❑ 42. Depression
❑ 11. Stroke (Date:_____)	❑ 28. Diabetes Oral Medication	❑ 43. Hepatitis, type A / B / C
❑ 12. Leukemia or Melanoma	❑ 29. Heart Attack	❑ 44. Muscular Dystrophy
❑ 13. Emphysema	❑ 30. Coronary Artery Disease	❑ 45. Other Heart Disorders
❑ 14. LUPUS	❑ 31. Liver Disorders	❑ 46. Other Mental/Emotional Disorders
❑ 15. Back / Spinal Disorder	❑ 32. Congenital Disease / Defect	❑ 47. Sexually Transmitted Disease
❑ 16. Bowel / Stomach Disorders	❑ 33. Other Neurological Disorders	
❑ 17. Lung Disorders	❑ 34. Kidney / Urinary Disorders	

7. MEDICAL QUESTIONS

	Yes	No
1) Within the past 5 years, have you or your dependents had, or been treated for cancer? If yes, explain in Section 8.	❑	❑
2) Within the past 3 years, have you or your dependents had, or been treated for, or been told that you have any other condition/disorder/disease not listed above? If yes, explain in Section 8.	❑	❑
3) Are you or any of your dependents to be covered requested or been advised in the last 12 months that hospitalization or surgery is needed or should be anticipated? If yes, explain in Section 8.	❑	❑
4) Are any dependents to be covered currently confined to a hospital, disabled or in any way unable to perform activities of their normal life?	❑	❑
5) Have you or your dependents ever been restricted from, or declined for coverage by any carrier, If yes, explain in Section 8.	❑	❑

8. EXPLANATION

Question #	Which Covered Member (Full Name)	Illness or Conditions	Date of Diagnosis, Medication, Treatment and Prognosis	Physician's Name

9. AGREEMENT

I acknowledge that I have read the above statements; or they have been read to me, and that I understand them. I declare and agree that the above answers and responses are, to the best of my knowledge and belief, complete, true, and together with any supplement thereto and with no intent to mislead nor deceive, shall be the basis for any certification of coverage and group policy issues. I understand and agree that neither the employer nor any agent has the authority to waive a complete response to any question, pass on coverage or insurability for me or the group, make or alter any contract, or waive any of the rights or requirements of SIHO. I hereby agree that no coverage will be effective until the date specified by SIHO on the certificate of coverage after this enrollment for application has been processed and accepted. I understand that any misrepresentation or omission contained herein relied on by SIHO may impact reduce, delay or void not only a future claim, but the actual prospective acceptance of the overall risk and/or the employees contract within the contestable period if such misrepresentation or omission affects the acceptance or the evaluation of this risk.

I authorize any physician, medical practitioner, hospital, clinic, Veterans Administration facility, other medical or medical-related facility, insurer, re-insurer, health maintenance organization. Medical Information Bureau, Inc., or Consumer Reporting Agency having information available as to diagnosis, treatment, prognosis and plan of first time treatment with respect to any physical or mental condition and/or treatments of me or my covered dependents and any other non-medical information of me or my covered dependents to give to SIHO or their legal representative any and all such information.

I understand the information referenced above and obtained be use of this authorization to be confidential and used by SIHO only to determine eligibility for coverage and eligibility for benefits under an existing policy. Any information obtained will not be released by SIHO to any person or organization except to reinsuring companies (who will treat the information as confidential and limit its use to its specific business), or other persons or organizations performing business or legal service in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize.

I know that I may request to receive a copy of this authorization. I agree that a photographic copy of this authorization shall be as valid as the original. I agree that this authorization shall be valid for two and one half years from the date of this enrollment form/application

10. AUTHORIZATION OF COVERAGE

If you elect coverage/application to the SIHO Health Plan, your signature below will attest to and acknowledge the following:

I agree that any benefit payable on my behalf under my employer's group health plan with SIHO may be paid directly to the provider of care. I authorize my employer to make the necessary deductions from my pay or any disability or retirement annuity benefits to which I may be entitled under any group plan sponsored by my employer which I am enrolled until this authorization is revoked by me in writing. I understand that I must be actively at work full-time on the effective date of coverage for any of my dependents (other than newborn children) may be delayed if that dependent is hospital confined or totally disabled as of the date of their membership enrollment/application form. I understand that, depending upon my certification of credible coverage, in the event that coverage becomes effective, benefits may not be payable or may be limited for any pre-existing condition (illnesses or injuries for which diagnosis, medical services or treatment was received or for which symptoms occurred which would cause a ordinarily prudent person to seek diagnosis, care, medical services or treatment prior to the effective date).

Upon signing, I agree to the following terms and conditions for myself and for any eligible dependents if coverage should become effective: I understand that if I (we) make any claim for benefit, or dispute any decision relative to a claim of benefit, it will be resolved according to the group policy. In fact, all benefits and coverage for my eligible dependents and myself will be provided in accordance with that group policy. I agree to abide by the terms and conditions governing membership and the receipt of health services benefits.

❑ **I elect to enroll/apply in the SIHO Health Plan**

_____	_____
Signature of Proposed Insured Employee	Date
_____	_____
Signature of Spouse (If applicable)	Date

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