Must be completed by Employer: ❑ **New Group**

Employer Name: _____

Client # and Sub Group #: _____ -- _____

Following Employee is:

❑ COBRA - Qualifying Event Date: _____

❑ New Hire by your Firm ❑ Other

❑ Applying during Open Enrollment

❑ Special Enrollment Event _____

Date Event Occurred: _____

Requested effective date of coverage: _____

2600 West 49th Street
P.O. Box 7406
Sioux Falls, SD 57117-7406
605-334-4000

DAKOTACARE®
THE HEALTH CARE PLAN OF THE SOUTH DAKOTA MEDICAL ASSOCIATION

LARGE GROUP
EMPLOYEE ENROLLMENT APPLICATION

(All areas must be completed to ensure prompt processing.)

Please PRINT Clearly

Applicant Information

Employee Social Security Number

			-			-				

Your SSN is required solely for the purpose of your positive identification by DAKOTACARE. Your SSN will be protected from disclosure and will not be released or disclosed to any person or party, unless required by law.

Legal Last Name | **Legal First Name** | **MI**

Mailing Address | Apt/Lot# | City | State | Zip

❑ Single ❑ Divorced ❑ Married Date of Event:	Phone No.	Gender ❑ M ❑ F	Date of Birth	Height	Weight
Date Employed Full-Time	❑ Salaried ❑ Hourly	Average Hours Worked Per Week	e-mail Address	Occupation	
This request for health coverage is for: ❑ Self ❑ Family ❑ Employee/Spouse ❑ Employee/Child(ren)			Group Life ❑ Single ❑ Family	Do you use tobacco? ❑ Y ❑ N	

Family Information – Include for Health & Life

Legal First Name and M.I. (legal last name if different)	Gender	Date of Birth	Height	Weight	Social Security No. (required)	Marital Status (circle one) S=Single M=Married	Relationship to Employee	If age 18 or older, do you use tobacco?
	❑ M ❑ F					S / M		❑ Y ❑ N
	❑ M ❑ F					S / M		❑ Y ❑ N
	❑ M ❑ F					S / M		❑ Y ❑ N
	❑ M ❑ F					S / M		❑ Y ❑ N
	❑ M ❑ F					S / M		❑ Y ❑ N

(If more space is needed, attach an additional sheet of paper, signed and dated)

*Eligible dependents may include spouse and natural dependent children, stepchildren, totally disabled children, adopted children, children of whom member has legal guardianship and children who are full-time students.

OTHER INSURANCE WAIVER SECTION

I have been informed that an employer-sponsored health benefit plan is available through my employer to my dependents and me. On behalf of myself and my dependents, I am voluntarily electing not to enroll in the health benefit plan sponsored by my employer. I am not applying for coverage because I am:

❑ Enrolled through the Health Insurance Marketplace (Exchange)

❑ Enrolled in a DAKOTACARE Individual Policy

❑ Covered by spouse's group benefit plan

❑ Other Explain: _____

Employee Signature: _____ Date:_____

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 your enrollment request is received 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 along with the newly acquired dependents, provided that your request for enrollment is received within 30 days following the marriage, birth, adoption or placement for adoption.

OTHER COVERAGE INFORMATION

Are you or any family member covered by any medical insurance, including Medicare, which will continue **AFTER** the proposed effective date with DAKOTACARE? ❑ No ❑ Yes*

*If yes, a copy of the Other Insurance or Medicare card **MUST** be attached.

Are you currently or have you previously been enrolled by DAKOTACARE?

❑ No ❑ Yes ID Number: _____

Do you have a court order which states who is responsible to provide medical coverage on the dependents? ❑ No ❑ Yes*

*If yes, a copy of the court order **MUST** be attached.

Life Insurance Beneficiary Section

Primary Beneficiary

Name: _____

Address: _____

Relationship: _____

Contingent Beneficiary

Name: _____

Address: _____

Relationship: _____

HEALTH HISTORY QUESTIONS EMPLOYEE & DEPENDENTS

1. Yes No Over the last five years, has any person to be insured incurred claims in excess of $5000?
2. Yes No Is any person to be insured receiving treatment, taking medication, or been advised of a condition that will require attention in the next 24 months (including pregnancy)? **If pregnant, is this a Multiple Birth pregnancy, i.e., twins, triplets?** ❑ **Yes** ❑ **No**
3. Yes No Has any person to be insured ever been diagnosed or treated for, HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex by a physician or member of the medical profession?
4. Within the past ten years, has any person to be insured ever had any symptoms, diagnosis, consultation, treatment, or taken any medication or received counseling for:

A. Alcohol/Drug Abuse	Yes	No	L. Epilepsy/Seizures	Yes	No	U. Pancreatic Disorder	Yes	No
B. Arthritis/Back/Joint Disorder	Yes	No	M. Genital/Urinary Disorder	Yes	No	V. Respiratory/Lung Disorder	Yes	No
C. Asthma	Yes	No	N. Heart/Blood/Vascular Disorder/			W. Skin Disease	Yes	No
D. Autoimmune Disorder	Yes	No	Stroke	Yes	No	X. Systemic Lupus/Multiple Sclerosis	Yes	No
E. Breast/Female Disorder	Yes	No	O. Hemophilia	Yes	No	Y. Tobacco Product Use	Yes	No
F. Cancer/Tumor	Yes	No	P. Hypertension/High Blood Pressure	Yes	No	Z. Transplants	Yes	No
G. Colitis/Crohn's Disease	Yes	No	Q. Kidney Disorder	Yes	No	AA. Tuberculosis or Hepatitis	Yes	No
H. Congenital Disorder or Deformity	Yes	No	R. Liver Disorder	Yes	No	BB. Currently Pregnant	Yes	No
I. Diabetes	Yes	No	S. Mental/Nervous Disorder	Yes	No	CC. Auto Accident or Workers' Compensation Case Pending	Yes	No
J. Digestive/Eating Disorder	Yes	No	T. Muscle Disorder/					
K. Ear/Eye Disorder	Yes	No	Neurological Disease	Yes	No			

5. List all medications prescribed by a physician in the last 12 months. Also, please indicate which medications any insured is **currently** taking: _____

*** * In the chart below, please provide details to ANY and ALL "Yes" answers from Questions 1-5.**

Question Number And Patient Name	Date of Onset	Diagnosis, Treatment, Or Reason For Medical Attention	Days In Hospital	Date Of Complete Recovery	Doctor/Address

IF SPACE PROVIDED IS INSUFFICIENT, PLEASE ATTACH SEPARATE SHEET OF PAPER, SIGNED AND DATED

Authorization to Release Information to DAKOTACARE

TO: Physicians, Hospitals and Other Providers of Health Care Services; Insurers; Employers; and Group Policyholders:

I request that you provide DAKOTACARE with any and all health, job status, or other information about me or any family member named on this application. I also request that you provide the above referred to information to the application department of any DAKOTACARE reinsurer requesting such information. Health information includes any and all records existing both prior to and subsequent to my application for health coverage with DAKOTACARE which may encompass: (a) my medical history; (b) my physical and mental health; and (c) my possible drug and alcohol use. Health information also includes any and all of the above referred to records which may be created or produced at any time in the future. The purpose of this release is to facilitate evaluation of my application, provide assistance in processing any claims submitted to DAKOTACARE, or for medical management programs and activities. A photocopy of this form is as valid as the original, and I may receive a copy of this form upon written request. This authorization is valid for the term of enrollment and this release is a waiver of any physician/patient privilege. I understand there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

Should DAKOTACARE become aware, at any time during the term of this Contract, that the Member or Enrolling Unit has committed fraud, or made an intentional misrepresentation of a material fact, on the Member's enrollment application, Employer's application, or any application for individual health coverage completed for the benefit of the Member or any dependent or any other person applying for coverage, DAKOTACARE reserves the right to rescind such Contract pursuant to ARSD 20:06:55:14.

DAKOTACARE reserves the right to deny benefits under the Contract if it becomes aware during the term of the Contract, that the Member or Enrolling Unit has made fraudulent, or intentional misrepresentations, or any representations that materially affect the acceptance of the risk by DAKOTACARE, pursuant to SDCL 58-11-44, in any application for coverage from DAKOTACARE, or its affiliates.

Authorization to Use Health Information for Life and Disability Insurance Purposes

I hereby authorize DAKOTACARE's underwriting department to use health information provided on my Employee Enrollment Application to provide life and/or disability insurance rates and coverage through my Employer.

Contract/Handbook Availability

The undersigned Employee/Member acknowledges and understands that his/her Employer/Enrolling Unit has been provided a copy of DAKOTACARE's Master Contract which the undersigned Employee/Member may consult at any time, and the undersigned Employee/Member can access the Member Handbook electronically at www.dakotacare.com or by contacting DAKOTACARE's Customer Service Department for a paper copy.

This application shall become a part of your DAKOTACARE contract.

X _____	**X** _____	**X** _____
Employee Signature	Date	Spouse Signature (if you are applying for your spouse)