UTAH SMALL EMPLOYER HEALTH INSURANCE APPLICATION

OFFICE USE ONLY
Policy / Group No.
Effective Date
PEC
New Hire Waiting Period

REASON FOR ENROLLMENT (mark all that apply)		
❒ New Group	❒ Newborn	❒ Loss of Coverage____________________
❒ Open Enrollment	❒ Court Order	❒ Marriage____________________
❒ New Hire	❒ Dependent Addition	❒ Divorce____________________
❒ New Application	❒ Other:___________	❒ Military Leave of Absence(USERRA)________
❒ COBRA	❒ Utah mini-COBRA	❒Alternative Coverage (Utah NetCare) for:
❒ Employee ❒ Dependent(s)		
Length of continuation coverage: ❒12 mos. ❒18 mos. ❒36 mos. ❒Other:		
Original Qualifying Event Date:	Qualifying Event Date:	Date of Event:
❒ **WAIVER OF COVERAGE** Individuals waiving coverage complete only Section J.		

A. EMPLOYER INFORMATION

Employer ______________________________ Hire Date ______________ Rehire Date ______________

Location ______________________ Is this a division? ❒ Yes ❒ No If "Yes," name of parent company ______________________

B. EMPLOYEE INFORMATION

Name (Last) ________________ (First)______________ (MI) _____ Job Title ______________ Hrs/Week ________

Marital Status ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Domestic Partner*

Address ______________________________ Apt. _______ City ______________ State _______ Zip __________

Home (or other) Phone (_____) ____________Business Phone (_____) ______________Email Address: ______________________

Spouse's Employer ____________________________ Spouse's Business (or other) Phone (_______) ______________________

C. ENROLLING EMPLOYEE / SPOUSE / DOMESTIC PARTNER* / DEPENDENTS

List yourself and all dependents applying for coverage. Attach a separate sheet if necessary.

	Name (Last, First, Middle)	Social Security # (for insurer use only)	Date of Birth MM/DD/YYYY	Age	Gender	Weight	Height
Employee					❒ Male ❒ Female	lbs.	
Spouse/ Domestic Partner*					❒ Male ❒ Female	lbs.	
Dependent					❒ Male ❒ Female	lbs.	
Dependent					❒ Male ❒ Female	lbs.	
Dependent					❒ Male ❒ Female	lbs.	

D. CURRENT/PRIOR COVERAGE INFORMATION

Indicate any health care coverage, Medicaid, or Medicare in effect within the last 24 months. This will be used to determine if you have creditable coverage or if benefits will be coordinated. If no health care coverage was in effect within the past 24 months, indicate NONE. If applicable, provide a copy of any applicable court documentation that shows who is responsible for the dependent(s)' health care coverage. Attach a separate sheet if necessary.

	Insurer (Including policyholder name, insurer name and phone number) Medicaid or Medicare	Date of Coverage MM/YYYY Start Date	End Date	Will coverage continue?	Type of Coverage (Check all that apply)		
Employee:				❒ Yes ❒ No	❒ Group ❒ Medical	❒ Individual ❒ Dental	❒ Governmental ❒ Other
Spouse/Domestic Partner*:				❒ Yes ❒ No	❒ Group ❒ Medical	❒ Individual ❒ Dental	❒ Governmental ❒ Other
Dependent:				❒ Yes ❒ No	❒ Group ❒ Medical	❒ Individual ❒ Dental	❒ Governmental ❒ Other
Dependent:				❒ Yes ❒ No	❒ Group ❒ Medical	❒ Individual ❒ Dental	❒ Governmental ❒ Other
Dependent:				❒ Yes ❒ No	❒ Group ❒ Medical	❒ Individual ❒ Dental	❒ Governmental ❒ Other

***Check with your employer to determine if domestic partner coverage is available.**

E. HEALTH STATEMENT

EACH QUESTION MUST BE CHECKED "YES" OR "NO." ALL questions must be answered and complete or the application will be returned. It is your responsibility to notify the insurer of any change in health status while this application is pending. The federal Genetic Information Nondiscrimination Act prohibits health insurers from requesting, requiring, purchasing, or collecting "genetic information" for underwriting purposes. **DO NOT REPORT GENETIC INFORMATION ON THIS FORM.** Information about manifested diseases or conditions of an applicant is not considered genetic information and is to be reported, even if the disease or condition is caused by or associated with genetics. The information provided in this section may be used for rate setting, risk-adjustment or coordination of care, but will not be used to deny coverage.

	HEALTH QUESTIONS	YES	NO
1	Is any applicant pregnant or financially responsible for an unborn child, or do you anticipate adopting a child in the next 12 months? If currently pregnant, provide expected due date________________________.		
	► Do you anticipate complications or multiple births?		
	► Have you had prior complications or multiple births?		
2	**Within the past 12 months** has any applicant:		
	A. Taken any prescribed medications for any health condition identified in Section E?		
	B. Been injected with a drug or medication by a health care provider excluding immunizations?		
	► Are all applicants' immunizations current?		
3	**Within the past 12 months** has any applicant used any form of tobacco, including but not limited to cigars, cigarettes, or chewing tobacco)? If applicant has quit using tobacco give approximate quit date:________________________		
4	**Within the past 5 years**, has any applicant applying for coverage been tested for or diagnosed with, had treatment recommended, received treatment, including prescription medications, or been hospitalized for any illness, injury, or health condition related to any of the categories listed below?		
	A. Cardiovascular disease or heart attack, stroke, high blood pressure, or any other diseases or disorders of the heart, arteries, blood, or blood vessels?		
	B. Asthma, emphysema, tuberculosis, or any other diseases or disorders of the lungs or respiratory system?		
	C. Diabetes or any other diseases or disorders of the pancreas? If yes, check all that apply: ❒ Non Insulin Dependent ❒ Insulin Dependent ❒ Insulin Pump		
	D. Hepatitis or any other diseases or disorders of the liver, stomach, colon, or intestines?		
	E. Chronic kidney stones or any other diseases or disorders of the kidney, prostate, or bladder?		
	F. Male or female reproductive organs or any other diseases or disorders including infertility?		
	G. Arthritis or any other diseases or disorders of the joints, muscles, back, or bones?		
	H. Mental health diseases or disorders or alcohol/drug abuse?		
	I. Seizures/epilepsy, paralysis, or any other diseases or disorders of the brain or nervous system?		
	J. Lupus or any other diseases or disorders of the immune system?		
5	**Within the past 5 years**, has any applicant applying for coverage been diagnosed or treated by a licensed medical professional for HIV, AIDS, or AIDS Related Complex?		
6	**Within the past 5 years**, excluding routine or preventative care, has any applicant applying for coverage been tested for or diagnosed with, had treatment recommended, received treatment, including prescription medications, or been hospitalized for any illness, injury or health condition not indicated above?		
7	Has any applicant **ever** had any organ or tissue transplant?		
8	Has any applicant **ever** had cancer (including skin cancer or melanoma)?		

IF ANY OF THE QUESTIONS IN THIS SECTION WERE CHECKED "YES", PROVIDE DETAILS IN SECTIONS F & G.

F. PRESCRIPTION INFORMATION WITHIN LAST 12 MONTHS Refer to Section E

IF ANY OF THE QUESTIONS IN SECTION E WERE CHECKED "YES", PROVIDE DETAILS IN THIS SECTION. Attach a separate sheet if necessary.

Name of Applicant	Name of Medication	Reason for medication (Name of Illness, Disorder or Treatment)	Start Date MM /YYYY	End Date MM/YYYY	Physician, clinic, or hospital name. If known, provide phone number or address.

G. ADDITIONAL INFORMATION Refer to Section E

IF ANY OF THE QUESTIONS IN SECTION E WERE CHECKED "YES", PROVIDE DETAILS IN THIS SECTION. Attach a separate sheet if necessary.

Question #	Name of Applicant	Explain diagnosis, illness, injury, treatment received, testing, consultations, future treatments, and remaining symptoms or problems.	Diagnosis / Treatment Date(s)		Physician, clinic, or hospital name. If known, provide phone number or address.
			Start Date MM /YYYY	End Date MM/YYYY	

H. DISABILITY INFORMATION

Are you or any dependent(s) disabled? ❒ Yes ❒ No If yes, indicate first and last name(s).______________________________

Reason for disability:______________________________

Is the disabled individual currently unable to perform routine daily functions for two weeks or more? ❒ Yes ❒ No

Have you or any dependent(s) filed workers' compensation claims or disability claims within the last five years? ❒ Yes ❒ No

If so, what is the status of the claims?______________________________

I. ACKNOWLEDGMENT AND SIGNATURE

I agree to abide by the insurer's enrollment provisions. I understand that coverage cannot start until after the waiting period. I authorize my employer to act as my agent in all matters of administration of the group program, and acknowledge that my employer is in no way acting as agent for the insurer.

I acknowledge that I have had the opportunity to waive coverage for myself and any eligible dependents that I have listed those waiving coverage, if any, in Section J, "Waiver of Coverage" of this application.

I understand that credit for prior coverage will be based upon the information contained in this application and/or proof of prior coverage, such as a Certificate of Creditable Coverage.

If the policy contains a voluntary arbitration provision: ANY MATTER IN DISPUTE BETWEEN YOU AND THE INSURER MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION OR OTHER RECOGNIZED ARBITRATOR, A COPY OF WHICH IS AVAILABLE ON REQUEST FROM THE INSURER. THE INSURER SHALL BEAR THE COSTS OF ARBITRATION, FILING FEES, ADMINISTRATIVE FEES AND ARBITRATOR FEES. OTHER EXPENSES OF ARBITRATION, INCLUDING, BUT NOT LIMITED TO: ATTORNEY FEES, EXPENSES OF DISCOVERY, WITNESSES, STENOGRAPHER, TRANSLATORS, AND SIMILAR EXPENSES, WILL BE BORNE BY THE PARTY INCURRING THOSE EXPENSES. ANY DECISION REACHED BY ARBITRATION SHALL BE BINDING UPON BOTH YOU AND THE COMPANY. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY'S FEES, IF ALLOWED BY STATE LAW, AND MAY BE ENTERED AS A JUDGMENT IN ANY COURT OF PROPER JURISDICTION.

I certify that all information completed on this form is true, accurate, correct and complete. I acknowledge that if any information provided is false, the insurer may without advance notice pursue any remedies available under state or federal law, including declaring the coverage null and void and canceling the coverage retroactive to its original effective date.

I have read the Acknowledgment of this document and agree to its terms. I have also completed an authorization to disclose protected health information form, if such form accompanies this application.

Employee Signature______________________________Date______________

J. WAIVER OF COVERAGE

COMPLETE WHEN WAIVING COVERAGE FOR SELF AND/OR DEPENDENTS

Employer: ____________________

Employee Name: (Last) ____________________ (First)____________________ (MI) __________

INDIVIDUALS WAIVING COVERAGE

Name of Individual waiving coverage	Insurer and phone number	Date of Coverage MM/YYYY		Will coverage continue?	Type of Coverage (Check all that apply)
		Start Date	End Date		
Employee:				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Governmental ❒ Medical ❒ Dental ❒ Other
Spouse / Domestic Partner:				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Governmental ❒ Medical ❒ Dental ❒ Other
Dependent:				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Governmental ❒ Medical ❒ Dental ❒ Other
Dependent:				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Governmental ❒ Medical ❒ Dental ❒ Other
Dependent:				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Governmental ❒ Medical ❒ Dental ❒ Other

HEALTH STATEMENT

	YES	NO
Pregnancy / Adoption: Is any individual waiving coverage pregnant or financially responsible for an unborn child? If currently pregnant, provide expected due date: __________.		
► Do you anticipate complications or multiple births?		
► Have you had prior complications or multiple births?		

IF "YES", PROVIDE DETAILS IN THIS SECTION Attach a separate sheet if necessary.

Name of Individual	Explain diagnosis, illness, treatment received, testing, consultations, future treatments, and remaining symptoms or problems	Diagnosis/Treatment date(s)		Physician, clinic, or hospital name. If known, provide phone number or address.
		Start Date MM /YYYY	Start Date MM /YYYY	

ACKNOWLEDGEMENT AND SIGNATURE

I acknowledge that I have had the opportunity to enroll, but do not wish to make application for those individual(s) listed above. In waiving coverage, I am aware that waiving individuals (including myself, if I am waiving) may not enroll until my group's anniversary, unless the waiving individual qualifies for a Special Enrollment Period (SEP). If I have waived enrollment for myself or any of my dependents (including my spouse) because of other health care coverage or group health plan coverage, I may in the future be qualified for a SEP and be able to enroll the waived individuals in this plan, provided I request enrollment within 30 days after the other coverage of the individual(s) ends due to loss of eligibility or an employer's ceasing to contribute toward that other coverage (within 60 days if the other coverage was Medicaid or CHIP). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I further certify that all information completed on this form is true, correct and complete, and acknowledge my coverage is subject to cancellation or other action permissible by law, if any completed information is found to be false or incorrect.

Employee Signature____________________Date____________________