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	❒ Marriage*	❒ Court Order*
❒ New Hire*	❒ Divorce*	❒ Other:
❒ New Application	❒ Re-apply	❒ Dependent Addition
* Date of Event		
❒ COBRA / Utah mini-COBRA / Alternative Coverage for:		
❒ Employee ❒ Dependent Employer Name:		
Length of COBRA continuation coverage: ❒ 18 mos. ❒ 36 mos. Other:		
Original Qualifying Event Date:	Qualifying Event Date:	Date of Event:

COVERAGE REQUESTED

Coverage	Self	Spouse	Child(ren)	COBRA	Utah mini-COBRA	Alternative Coverage
Medical	❒	❒	❒	❒	❒	❒
Dental	❒	❒	❒	❒	❒	❒
Vision	❒	❒	❒	❒	❒	❒

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 ❒ Legally Married ❒ Single ❒ Divorced ❒ Widowed ❒ Domestic Partner

Address _____ Apt. _____ City _____ State _____ Zip _____

Home (or other) Phone (_____) _____ Business Phone (_____) _____

Spouse's Employer _____ Spouse's Business (or other) Phone (_____) _____

Driver's License Number: _____ Email Address: _____

C. ENROLLING EMPLOYEE / SPOUSE / DEPENDENTS (attach separate sheet if necessary)

In the section below, list yourself and all eligible family members to be included under coverage.

	Social Security # (for internal use only)	Name(Last, First, MI)	Date of Birth	Age	M/F	Weight	Height	Medical Coverage	Rx Coverage	HICN
Employee						lbs.		❒ Yes ❒ No	❒ Yes ❒ No	
Spouse						lbs.		❒ Yes ❒ No	❒ Yes ❒ No	
Dependent						lbs.		❒ Yes ❒ No	❒ Yes ❒ No	
Dependent						lbs.		❒ Yes ❒ No	❒ Yes ❒ No	
Dependent						lbs.		❒ Yes ❒ No	❒ Yes ❒ No	
Dependent						lbs.		❒ Yes ❒ No	❒ Yes ❒ No	

Eligible family members include spouse, natural child, stepchild, adopted child, child placed for adoption, and child for whom you are appointed as legal guardian by the court. To be eligible for coverage, children must be under the age of 26, unmarried, and dependent upon you for 50 percent of their financial support. Financial dependency is not required for court-ordered child coverage. Any dependent not listed will not be considered for coverage.

D. WAIVER OF COVERAGE

- Complete this section for yourself (if waiving) and/or any of your dependents for whom you are waiving coverage. You may not enroll dependents if you are waiving, except children subject to a Qualified Medical Child Support Order.
- If you decline enrollment in this plan for yourself and/or any of your dependents, including your spouse, because of other health care coverage, you may in the future be able to enroll the omitted individual(s) in this plan, provided that you request enrollment within 30 days after the other coverage of the individual(s) ends. ("Decline enrollment" includes omission of the individual from this application.) 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 30 days after the marriage, birth, adoption, or placement for adoption, the Special Enrollment Period.
- Please complete type of health care coverage for the employee and all eligible members who have other health care coverage by completing type of health care coverage, i.e.; group, individual or other (Medicare, Medicaid, V.A., H.I.P., etc.).
- All eligible family members must be listed in this section or the ENROLLING EMPLOYEE / SPOUSE / DEPENDENTS section.

Persons waiving coverage. Include last name if different from employee. No nicknames, please.	Birth Date MM/DD/YYYY	Other Health Care Coverage	Type of Health Care Coverage			Insurer Name	Reason for Waiver
			Group	Individual	Other (explain)		
Employee:		❒ Yes ❒ No					
Spouse:		❒ Yes ❒ No					
Dependent:		❒ Yes ❒ No					
Dependent:		❒ Yes ❒ No					
Dependent:		❒ Yes ❒ No					
Dependent:		❒ Yes ❒ No					

E. CURRENT/PRIOR COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health care coverage, including Medicare or Medicaid, in effect within 24 months prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health care coverage was in effect within the past 24 months, please indicate NONE. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care coverage so that the insurer can determine whose coverage is primary.

Enrolling Individual(s): (Non-Medicare)	Insurer (Including policyholder name, insurer name and phone number)	Date of Coverage Month/Day/Year		Will the individual continue this coverage?	Type of Coverage (Check all that apply)
		From	To		
Employee:				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Dental ❒ Medical
Spouse:				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Dental ❒ Medical
Dependent:				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Dental ❒ Medical
Dependent:				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Dental ❒ Medical
Dependent:				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Dental ❒ Medical
Dependent:				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Dental ❒ Medical

MEDICARE: If you or any family members listed on this application have Medicare, is coverage ❒ Part A ❒ Part B ❒ Part D and please complete the following information. Please submit a copy of your Medicare ID card with this application.

Enrolling Individual:	Effective Date / /	Medicare Number (please include alpha prefix)	Reason for Medicare Entitlement: ❒ Age ❒ Disability ❒ ESRD ❒ Dual Enrollment
Enrolling Individual:	Effective Date / /	Medicare Number (please include alpha prefix)	Reason for Medicare Entitlement: ❒ Age ❒ Disability ❒ ESRD ❒ Dual Enrollment

Note: If you have had health care coverage within the last 63 days, your Pre-Existing Condition (PEC) waiting period limitation may be partially or completely waived. To determine if this applies to you, you must provide proof of prior coverage, such as a Certificate of Creditable Coverage from your previous insurer. Submission of prior coverage information does not automatically waive any PEC limitation. However, you will be subject to an automatic PEC Waiting Period of up to 12 months until we receive evidence of prior coverage.

F. 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 dependent 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? _____

G. HEALTH STATEMENT

IF ANY OF THE BELOW CONDITIONS OR QUESTIONS ARE CHECKED "YES" PROVIDE DETAILS IN SECTIONS H. & I. ON THE FOLLOWING PAGE.
The federal Genetic Information Nondiscrimination Act prohibits health insurers from requesting, requiring, purchasing, or collecting "genetic information" for underwriting purposes. "Genetic information" includes your genetic tests, the genetic tests of your family members, and the manifestation of a disease or disorder in family members not covered by the policy. Genetic information can also include requests for, or receipt of, genetic services, or participation in clinical research which includes genetic services. Do not report genetic information on this form. However, information about manifested diseases or conditions of anyone applying for coverage is not considered genetic information and is to be reported on this form, even if the disease or condition is caused by or associated with genetics.

EACH QUESTION MUST BE CHECKED "YES" OR "NO." This health statement must be complete or the application will be returned. Inaccurate health information may result in the coverage being cancelled retroactively. It is your responsibility to notify the insurer of any change in health status while application is pending.

	Respond to the following questions:	YES	NO
1	**Pregnancy/Adoption:** Are you, your spouse, or any dependent family member pregnant or financially responsible for an unborn child, or do you anticipate adopting a child in the next 12 months?		
2	**Pregnancy/Fertility Related Treatment:** Are you, your spouse, or any dependent family member being treated for infertility, fertility evaluation or treatment (including medication), miscarriage, complications related to pregnancy (including premature births)?		
3	**Last Menstrual Period:** Have you, your spouse or any eligible child (whether or not proposed for insurance) missed her last menstrual period? If yes, provide date of last menstrual cycle on the following page.		
	Within the past 12 MONTHS has any applicant:	**YES**	**NO**
4	**Prescriptions/Medications/Immunizations:** Been prescribed or taken any prescription or over-the-counter medications, drugs, or shots (including immunizations, birth control, etc.)?		
5	**Conditions Requiring Follow Up Medical Consult/Treatment:** Do you, your spouse or any dependent family member have a condition for which hospitalization, tests, consultation, evaluation, surgery, or medication have been advised, but not completed?		
6	**Medical Consult/Treatment:** Consulted or received treatment from a doctor, chiropractor, counselor, therapist, or other health care provider, including routine & wellness care?		
7	**Conditions Requiring Initial Medical Consult/Treatment:** Had a health condition, problem, disorder, or any other medical or mental health conditions not listed for which medical or mental health advice or treatment has not been sought ?		
	Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following:	**YES**	**NO**
8	**Urinary, bladder, incontinence, kidney or liver conditions or disorders:** Kidney stones, jaundice, nephritis, or any other disorder of the liver, kidneys, or pancreas?		
9	**Neurological Disorders:** Recurring headaches, migraines, head injury, epilepsy, seizures, convulsions, or other neurological disorder?		
10	**Metabolic and Endocrine Conditions/Disorders:** Lupus, thyroid disorder, goiter, or any other lymph system disorder?		
11	**Eyes, ears, nose, sinus, or throat conditions/disorders** or any other respiratory system disorder, including allergies or hay fever?		
12	**Skin Conditions/Disorders:** Acne, psoriasis, eczema, growths (except warts), abnormal moles, abnormal birthmarks, or any other skin disorder?		
13	**Breast Conditions/Disorders:** Breast lumps, breast augmentation, or breast reduction?		
14	**Heart Conditions/Disorders:** Chest pain, high blood pressure, high cholesterol, irregular heart beat, or any other heart condition?		
15	**Back, neck, bone, joint or spinal disorder:** bone or joint disorders (including foot, knee, jaw, fracture, dislocation, or joint replacement)?		
16	**Blood Conditions/Disorders:** Hemophilia, anemia, blood, or bleeding disorder?		
17	**Male Reproductive Conditions/Disorders:** Impotence, prostate or testicular disorder, abnormal PSA, or other reproductive disorder?		
18	**Circulatory System Conditions/Disorders:** Varicose veins, or any other circulatory disorder?		
19	**Hospitalization/Surgery:** Have you, your spouse, or any dependent family member been hospitalized or had surgery?		
20	**Sexually transmitted diseases**?		

	Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following (cont.):	YES	NO
21	**Female Reproductive Conditions/Disorders:** Irregular bleeding, abnormal Pap smear/test, endometriosis, recurring pelvic pain, pelvic inflammatory disease, or any other disorder of the reproductive system?		
22	**Digestive Conditions/Disorders:** Ulcers, hernias, chronic diarrhea, diverticulitis, diverticulosis, irritable bowel syndrome, reflux, GERD, any other gallbladder or digestive disorder, hemorrhoids, polyps, or any other rectal disorder?		
23	**Nervous, Mental and Behavioral:** Mental health counseling, psychotherapy, depression, stress, anxiety, attention deficit hyperactivity disorder (ADHD), mental health disorder, or chemical imbalance that required consultation or medication?		
	Within the past 10 YEARS has any applicant been diagnosed with or treated for any of the following:	**YES**	**NO**
24	**Gout, arthritis, Rheumatoid arthritis, fibromyalgia, or scleroderma?**		
25	**Musculoskeletal Conditions/Disorders:** Ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc, spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, spondylosis, or other musculoskeletal disorder?		
26	**Digestive Conditions/Disorders:** Crohn's disease. Colitis, colostomy, ilesotomy, or other digestive disorder?		
27	**Alcohol or Drug Use/Abuse:** been advised to reduce/limit alcohol use, or attended Alcoholics Anonymous (or similar program) for his/her own alcohol consumption, drug dependency, abuse, or misuse of prescribed or non-prescribed drugs such as opiates, stimulants, depressants, and/or hallucinogens?		
28	**Eating Disorders/Obesity Treatment:** including bulimia, anorexia, or obesity and any surgical services for obesity.		
29	**Respiratory Conditions/Disorders:** RSV, reactive airway disease, tuberculosis, asthma, sleep apnea, pleurisy, COPD, sarcoidosis, or emphysema?		
30	**Tobacco** use (chewing or smoking)? Quit Date: _____		
	Has any applicant EVER been diagnosed with or treated for any of the following:	**YES**	**NO**
31	**Birth Defects/Congenital Abnormalities:** premature birth, development or learning disability, mental impairment, Down syndrome, or autism spectrum disorder?		
32	**Nervous, Mental and Behavioral:** Bipolar affective disorder, manic depression, schizophrenia, chronic organic brain syndrome, or psychotic disorder?		
33	**Transplant or Implanted Device**: Any organ or tissue transplant, pacemaker, or other implanted device?		
34	**Heart and Circulatory Conditions/Disorders:** Heart murmur, heart attack, bypass surgery, angioplasty/stent, blood clot, stroke, heart surgery, coronary artery disease, or congestive heart failure?		
35	**Brain/Nervous System Conditions/Disorders:** Multiple sclerosis, muscular dystrophy, cerebral palsy, Lou Gehrig's disease (ALS), Parkinson's disease, Alzheimer's disease, or dementia?		
36	**Diabetes** (type I or II), insulin resistance?		
37	**Immune System Conditions/Disorders:** Immune system diseases, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC)?		
38	**Cancer/Tumors:** (including skin cancer or melanoma) or tumors?		
39	**Urinary/Liver Conditions/Disorders:** Cirrhosis, hepatitis, or renal failure?		
	OTHER MEDICAL INFORMATION	**YES**	**NO**
40	Any medical condition or treatment that you are unsure of where it fits in above? _____		

H. ADDITIONAL INFORMATION (Attach a separate sheet for additional information if necessary)

Question #	Name of Individual	Diagnosis, illness, injury, treatment received, testing, medical attention, medications, future treatments	Start Date mm/dd/yy	End Date mm/dd/yy	Remaining symptoms or problems	Name & phone of physician or hospital	
						Name	Phone #

I. PRESCRIPTION INFORMATION WITHIN LAST 12 MONTHS (Attach a separate sheet for additional information if necessary)

Question #	Name of individual	Name of Medication	Dosage	Start Date mm/dd/yy	End Date mm/dd/yy	Reason for medication	Name & phone of physician or hospital	
							Name	Phone #

J. ACKNOWLEDGMENT AND SIGNATURE

I agree to abide by the insurer's enrollment provisions. I understand that coverage cannot start until after I have served the waiting period agreed to by the employer as recorded on the insurer's records. 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 understand there may not be participating providers in all specialty fields.

I acknowledge that I have had the opportunity to enroll, but do not wish to make application for those individual(s) listed in the WAIVING OF COVERAGE section above (or any eligible family member not listed in the ENROLLING EMPLOYEE / SPOUSE/ DEPENDENTS section above). In waiving coverage, I am aware that waiving members (including myself, if I am waiving) may not enroll until my group's anniversary, unless the waiving member 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. 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 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 that I have obtained from my prior health care insurer(s) and provided to the insurer.

If any information provided is false or incomplete, the insurer may without advance notice pursue any remedies available under state or federal law, including but not limited to: declaring the coverage null and void and canceling the coverage retroactive to its original effective date; or imposing the pre-existing condition waiting period and denying claims that are pre-existing, subject to credit for prior 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 further certify that all information completed on this form is true, correct and complete and acknowledge my coverage may be subject to cancellation or other action permissible at law, if any completed information is found to be false or incorrect.

I attest that all information on this form is accurate. 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 _____

(A faxed signature shall be valid as an original signature.)