

This application is to be used for new enrollment groups with 20 or more medical lives.

Please either mail this application to SIHO, 417 Washington Street, Columbus, IN 47201
attn: Membership, fax it to 812-373-8717 or email to membership@siho.org.

SIHO Use Only ID # _____	
Plan: _____	Prex: _____
Network: _____	Group#: _____

1. Personal Information

EMPLOYEE NAME _____ DATE OF HIRE _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____ HOME PHONE # _____

2. PERSONS TO BE COVERED:

	Name	Sex M/F	Date of Birth	Weight	Height	Social Security #	Tobacco User? Y/N	Primary Care Physi- cian (REQUIRED)
01 Employee								
02 Spouse								
03 Child								
04 Child								
05 Child								
06 Child								

3. Health Plan you are selecting: Please see your employer if you are unsure about the plan(s)

Please circle one choice in each column:

<u>Select Product</u>	<u>Landmark Combined</u>		<u>Deductible Amount</u>	
Prime Care Choice	Yes	No	\$500	\$2,500
HSA	Yes	No	\$1,000	\$3,500
HRA	Yes	No	\$1,500	\$5,000
SIHO Secure	Yes	No	\$2,000	\$7,500
Cape Plus	N/A		\$10,000	

LIFE Only: Please complete 1 and 2 above and below and sections 4 and 5 on page 2.

Dependent Life: Please check for Life Insurance coverage for all dependents.

Enrollment status for which you are Applying/Enrolling. Please indicate Coverage Type for each Plan you are eligible for:

<u>Coverage Type</u>	<u>Plan</u>
E Employee Only	Medical _____
ES Employee & Spouse	Dental _____
EC Employee & Children	Vision _____
F Employee & Family	

Voluntary Plan(s) Selected:	
Choose one Dental Plan:	Choose one Vision Plan:
____ Preferred	____ 12 months/12 months
____ Standard	____ 12 months/24 months
____ Value	

4. WAIVER SECTION

Complete this Section **ONLY** if you, the employee, are **Waiving (declining) the health coverage available to you through your employer.**

WAIVER: This is to acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents. I hereby waive the health coverage offered. I am waiving the health coverage and declining to enroll because:

Spousal Coverage Coverage Under Another Plan
 Individual Health Coverage Coverage Under Another Plan from employer
 Other: _____ Medicare, Medicaid, or Medicare Supplement Coverage

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

I attest that I was not pressured nor forced by the employer, the writing agent, SIHO, or any other outside party who might have a vested interest in my waiving (declining) 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 statement of health for any future enrollment. I freely and voluntarily waive (decline) the coverage.

SIGN ONLY IF YOU ARE DECLINING COVERAGE IN THE SIHO MEDICAL PLAN

Signature of Employee

Date

5. Please complete if group is applying for life insurance

Request for Nomination of Beneficiary:

The right is reserved to change the beneficiary hereby designated, without the consent of said beneficiary. If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries (or beneficiary) as survives the insured, unless otherwise provided herein. If no beneficiary survives the insured, settlement will be made in accordance with the terms of the Policy(ies).

Beneficiary Last Name	Beneficiary First Name	Beneficiary Social Security #	Date of Birth	Relationship	Percent (%) of Benefit
PRIMARY					
SECONDARY					
OTHER					

7. Agreement and Authorization of Coverage

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 understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

I understand that the following parties may need to collect information on me or my covered dependents in regard to the proposed coverage: SIHO and its reinsurers, any insurance support organization, any consumer reporting agency, and all persons authorized to represent these organizations for this purpose.

I authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, or medically related facility, the Medical Information Bureau ("MIB") or other organization, institution or person that has knowledge or records of me and my covered dependents and our health, to disclose information as allowed or required by law. Such information includes any and all individually identifiable health information, including our entire medical records and any other protected health information. I understand that this authorization is needed for the purpose of gathering information for making eligibility, underwriting, and risk rating determinations. I understand that 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.

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 or the effective date will be the date I return to work full-time. I also understand that 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 (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 by the Enrollee within the 6-month period ending on the effective date of the Enrollee's enrollment in the Health Plan.

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 understand that I can revoke this authorization at any time by giving written notice to SIHO. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation. If I wish to revoke this authorization, I only need to go back to the requesting entity rather than the data sources and/or providers.

Group Dental Coverage is provided under the Group Dental Insurance Policy GH-1112-39160 issued to the Employers' Voluntary Benefit Insurance Trust insured by Security Life Insurance Company of America, Minnetonka, MN. Group Vision Coverage is provided under the Group Vision Policy GH-1157 or under the Group Vision Policy GH-1154 issued to the Group Policyholder insured by Security Life Insurance Company of America, Minnetonka, MN.

I understand that unless otherwise required by law, SIHO will provide all required regulatory notices via its website at www.siho.org and to my employee. I may also receive a printed copy of regulatory notices upon request.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Unless revoked earlier, this authorization will be valid for thirty (30) months after the date it is signed.

I elect to enroll/apply in the SIHO Medical Health Plan

Signature of Proposed Insured Employee or Personal Representative

Date

Description of Personal Representative Authority