

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.

INSURANCE APPLICATION EMPLOYEE ENROLLMENT

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

This application is to be used for new enrollment groups with 2-19 medical lives and all new hires.

1. REASON FOR COMPLETING THIS FORM

This form is completed in order to officially: Apply as New Enrollee Waive/Decline Coverage **EFFECTIVE DATE:** Month _____ Day _____ Year _____

I am a: New Employee Current Employee Special Enrollee
What is the qualifying event? Loss of Coverage Divorce Other **Date of Qualifying Event**
 ___ / ___ / ___

2. PERSONAL INFORMATION

Last Name _____ First Name _____ Middle Initial _____
 Address _____ City _____ State _____ Zip _____
 Social Security # _____ Email Address _____
 Home Phone _____ Work Phone _____ Birth Date _____
 Marital Status: Single Married Separated Divorced Widowed
 Company Name/Employer _____ Location _____
 Job Title _____ Date of Full Time Hire ___ / ___ / ___
 Weekly Hours Worked: Less than 20 Between 20 and 30 Over 30 40 Hours and Over

3. PLAN SECTION

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

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
HSA	Yes	No	\$1,000
HRA	Yes	No	\$1,500
SIHO Secure	Yes	No	\$2,000
Care Plus	N/A		\$2,500
			\$3,500
			\$5,000
			\$7,500
			\$10,000

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: _____ Preferred _____ Standard _____ Value	Choose one Vision Plan: _____ 12 months/12 months _____ 12 months/24 months
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- LIFE Only:** Please complete 01 below and sections 4 & 5 on page 2.
- Dependent Life:** Please check for Life Insurance coverage for all dependents.

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 (REQUIRED)	Tobacco User Y/N
01 Self										
02 Spouse										
03 Child										
04 Child										
05 Child										
06 Child										
07 Child										

4. OTHER HEALTH INSURANCE COVERAGE INFORMATION

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

Are you covered under Employer's current Health Plan? Yes No

If yes, please attach Certificate of Credible Coverage.

If married:

Spouse's name: _____ Birth Date _____

Is your spouse employed? Yes No If yes, Employer: _____

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

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

Note: You must notify SIHO within 30 days of any changes in other insurance coverage.

5. LIFE INSURANCE INFORMATION

You must notify SIHO of any Beneficiary Changes.

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					

6. COMPLETE ONLY IF EMPLOYEE IS DECLINING MEDICAL COVERAGE

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 Coverage Under Another Plan
 Individual Health Coverage 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.

SIGN ONLY IF DECLINING COVERAGE

Employee Signature: _____ Date: _____

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

7. STATEMENT OF HEALTH STATUS FOR INDIVIDUALS TO BE COVERED

Check all medical condition/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 9)

<input type="checkbox"/> 1. Transplant	<input type="checkbox"/> 18. Asthma	<input type="checkbox"/> 35. Heart Surgery
<input type="checkbox"/> 2. AIDS / AIDS Related Complex	<input type="checkbox"/> 19. Paralysis	<input type="checkbox"/> 36. Congestive Heart Failure
<input type="checkbox"/> 3. Arthritis	<input type="checkbox"/> 20. Multiple Sclerosis	<input type="checkbox"/> 37. Pacemaker
<input type="checkbox"/> 4. Rheumatoid Arthritis	<input type="checkbox"/> 21. Cerebral Palsy	<input type="checkbox"/> 38. Ischemic Heart Disease
<input type="checkbox"/> 5. Thyroid Disease	<input type="checkbox"/> 22. Epilepsy	<input type="checkbox"/> 39. High Blood Pressure
<input type="checkbox"/> 6. Spina Bifida	<input type="checkbox"/> 23. Parkinson's Disease	<input type="checkbox"/> 40. Currently Pregnant If so, state expected date: _____ / _____ / _____
<input type="checkbox"/> 7. Ulcerative Colitis	<input type="checkbox"/> 24. Alzheimer's Disease	
<input type="checkbox"/> 8. Diverticulitis	<input type="checkbox"/> 25. Hemophilia	
<input type="checkbox"/> 9. Crohn's Disease	<input type="checkbox"/> 26. Juvenile Diabetes	<input type="checkbox"/> 41. Alcohol or Drug Dependency
<input type="checkbox"/> 10. Gastric / Peptic Ulcer	<input type="checkbox"/> 27. Diabetes Insulin Dependent	<input type="checkbox"/> 42. Depression
<input type="checkbox"/> 11. Stroke (Date: _____)	<input type="checkbox"/> 28. Diabetes Oral Medication	<input type="checkbox"/> 43. Hepatitis, type A / B / C
<input type="checkbox"/> 12. Leukemia or Melanoma	<input type="checkbox"/> 29. Heart Attack	<input type="checkbox"/> 44. Muscular Dystrophy
<input type="checkbox"/> 13. Emphysema	<input type="checkbox"/> 30. Coronary Artery Disease	<input type="checkbox"/> 45. Other Heart Disorder
<input type="checkbox"/> 14. LUPUS	<input type="checkbox"/> 31. Liver Disorder	<input type="checkbox"/> 46. Other Mental/Emotional Disorder
<input type="checkbox"/> 15. Back / Spinal Disorder	<input type="checkbox"/> 32. Congenital Disease / Defect	<input type="checkbox"/> 47. Sexually Transmitted Disease
<input type="checkbox"/> 16. Bowel / Stomach Disorder	<input type="checkbox"/> 33. Other Neurological Disorder	<input type="checkbox"/> 48. High Cholesterol
<input type="checkbox"/> 17. Lung Disorder	<input type="checkbox"/> 34. Kidney / Urinary Disorder	

8. MEDICAL QUESTIONS

1) Within the past 5 years, have you or your dependents had, or been treated for cancer? If yes, explain in Section 9.	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>
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 9.	<input type="checkbox"/>	<input type="checkbox"/>
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 9.	<input type="checkbox"/>	<input type="checkbox"/>
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? If yes, please explain in Section 9.	<input type="checkbox"/>	<input type="checkbox"/>
5) Are you or your dependents currently taking any prescription medications? If yes, list all in Section 9.	<input type="checkbox"/>	<input type="checkbox"/>
6) Do you or your dependents participate in a High Risk Activity* on a regular basis? If yes, list all in Section 9.	<input type="checkbox"/>	<input type="checkbox"/>

9. EXPLANATION

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

Below, please list all medications not disclosed above.

Which Covered Member (Full Name)	Illness or Conditions	Medication	Physician's Name

* **"High Risk Activity"** is any sport or activity where one can reasonable expect that serious injury or illness may occur. High Risk Activities include but are not limited to: skydiving, hang gliding, parasailing, bungee jumping, scuba diving, motor vehicle racing, snow ski jumping and white water rafting.

10. 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 creditable 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(s). 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