SIHO INSURANCE SERVICES

INSURANCE APPLICATION
EMPLOYEE ENROLLMENT

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.

This application is to be used for new enrollment groups with 51 or more medical lives and all new hires.

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

1. REASON FOR COMPLETING THIS FORM

This form is completed in order to officially: ☐ Apply as New Enrollee ☐ Life Only (complete sections 2, 5, 6)

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** ___/___/___

If enrollment is due to a qualifying event, proof of qualifying event (divorce decree, Certificate of Creditable Coverage, Medicaid or other) **must** accompany application.

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 ____ / ____ / ____ Date of Rehire ____ / ____ / ____

Weekly Hours Worked: ☐ Less than 30 ☐ 30 to 39 ☐ 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:

Select Product
Prime Care Choice
HSA
HRA
Care Plus

Landmark Combined
Yes No
Yes No
Yes No
N/A

HMO Product
Yes No

Deductible Amount

$500	$2,500
$1,000	$3,000
$1,200	$3,500
$1,500	$5,000
$2,000	

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

Coverage Type		Plan
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

☐ **Dependent Life**: Please check for Life Insurance coverage for your depend-

Please complete the table below for each person that will be covered.

	Last Name	First Name	Social Security #	Height	Weight	Birth Date	Sex F/M	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 If no, reason:_____

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

If yes, please attach Certificate of Credible Coverage.

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" type of coverage ☐ Medical ☐ Dental ☐ Vision

If yes, who will be covered? ☐ 01Self ☐ 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.

OTHER Insurance Company Name or Plan (including Medicare Part A, B or both):

_____

Applicable only if you or a family member are covered by Other Health Insurance.

Address: _____

5. LIFE INSURANCE INFORMATION (required of all groups under 50 FTE)

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 3. 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)*

I am annually enrolled in:
- ☐ Spousal Coverage
- ☐ Individual Health Coverage

I have:
- ☐ Coverage Under Another Plan
- ☐ 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, 2 and 5 are completed if you waive or decline coverage.

7. MEDICAL QUESTIONS

Check all medical conditions/diseases listed below for which you or any of your dependents have been diagnosed, treated or counseled within the past 3 years: (Use number to identify conditions in Section 8)

- ☐ 1. Transplant
- ☐ 2. AIDS / AIDS Related Complex
- ☐ 3. Rheumatoid Arthritis
- ☐ 4. Spina Bifida
- ☐ 5. Ulcerative Colitis
- ☐ 6. Crohn's Disease
- ☐ 7. Stroke (Date:_____)
- ☐ 8. Lung Disorder
- ☐ 9. Multiple Sclerosis
- ☐ 10. Cerebral Palsy
- ☐ 11. Hemophilia
- ☐ 12. Juvenile Diabetes
- ☐ 13. Diabetes Insulin Dependent
- ☐ 14. Heart Disease
- ☐ 15. Liver Disorder/Hepatitis
- ☐ 16. Congenital Disease / Defect
- ☐ 17. Kidney / Urinary Disorder
- ☐ 18. Cancer
- ☐ 19. Congestive Heart Failure
- ☐ 20. Currently Pregnant

  If so, state expected date:

  _____ /_____ /_____

8. 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

9. 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 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

Explanation of Benefits (EOB) preference

(Please choose one): ☐ Email Notification or ☐ Print

Apply to all under 18 dependents ☐ Yes ☐ No