

Last Name

05 Child

06 Child

07 Child

INSURANCE APPLICATION EMPLOYEE ENROLLMENT FORM

800-443-2980 GROUP #: . REASON FOR COMPLETING THIS FORM I am a: ☐ New Employee This form is ■ Apply as New Enrollee completed in □ Current Employee Add Dependents order to ■ Late Enrollee Waive/Decline Coverage officially: DATE TO BE EFFECTIVE: Month _____ Day Year 2. PERSONAL INFORMATION First Name ____ Middle Initial _____ Last Name ___ City _____ State ____ Zip ____ Address _____ Work Phone Home Phone ☐ Divorced ☐ Widowed Marital Status:

Single Married Separated Company Name/Employer Date of Hire Annual Salary \$ Job Title Weekly Hours Worked: Less than 20 ☐ Over 30 ☐ 40 Hours and Over ☐ Between 20 and 30 Employment Status:

Active ☐ COBRA COBRA Expiration Date: 3. PLAN SECTION Health Plan that you selected: **Prime Care Choice Plan:** ☐ Choice 250 ☐ Choice 500 ☐ Choice 750 ☐ Choice 1000 ☐ Choice 2500 SIHO BasicCare: □ \$500 Ded. Plan □ \$1000 Ded. Plan □ \$2500 Ded. Plan SIHO Select Savings: ☐ HDHP \$1000 ☐ HDHP \$2500 □ SDHP \$250 □ SDHP \$500 □ SDHP \$750 Enrollment Status for which you are Applying/Enrolling (please choose one) ■ Employee ONLY ☐ Employee & Spouse ☐ Employee & Children ☐ Family ☐ LIFE Only (please complete section 4 and 5) Please complete the table below for each person that will be covered.

			F/M		Employee*	Physician	Student Y/N
01 Self							
02 Spouse							
03 Child							
04 Child							

Social Security # Birth Date Sex Height Weight Relation to Primary Care

Full-time

(* D = Dependent; SC = Step Child, please provide documentations)

First Name

3. PLAN SECTION (co	ntinued)						
Are you currently active at work	☐ Yes	□ No					
Are you currently covered under If yes, please attach Certificate of C	Employer's Plan?	☐ Yes	□ No				
If your spouse is to be covered,	please complete the follo	wing info	ormation: ls	s your spouse e	employed? 🖵 Yes	□ No	
If yes, Employer: Spouse's name:							
Will you or any member of your family be covered under <u>OTHER</u> health or medical insurance by divorce decree or any other reason?							
If yes, who will be covered?	☐ 01Self ☐ 05 Child						
OTHER Insurance Company Name	e or Plan:						
Address:							
Policy # (should be listed on card):				Effective Date):		
4. LIFE INSURANCE IN	NFORMATION						
Beneficiary Last Name	Beneficiary First Name	ne Beneficiary Socia		ial Security #	Date of Birth	Relationship	
PRIMARY							
SECONDARY							
5. MEDICAL WAIVER	SECTION						
Complete this Section ONLY if you are Waiving (declining) the health coverage available to you through your employer. 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 □ 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.							
Employee Signature:	Date:						

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

6. STATEMENT OF HEALTH STATUS FOR INDIVIDUALS TO BE COVERED

Check all medical conditions/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 8)

ם 1. Tra	nsplant	☐ 18. Asthma	☐ 18. Asthma		☐ 35. Heart Surgery				
□ 2. AID	OS/AIDS Related Complex	☐ 19. Paralysis		☐ 36. Congestive	e Heart Failure	eart Failure			
☐ 3. Artl	hritis	20. Multiple Scler	osis	☐ 37. Pacemake	r				
☐ 4. Rhe	eumatoid Arthritis	21. Cerebral Pals	у	☐ 38. Ischemic Heart Disease					
☐ 5. Thy	roid Disease	☐ 22. Epilepsy		☐ 39. High Blood Pressure					
☐ 6. Spi	na Bifida	23. Parkinson's D							
☐ 7. Ulc	erative Colitis	☐ 24. Alzheimer's D	☐ 24. Alzheimer's Disease If so, state expected d						
☐ 8. Div	erticulitis	☐ 25. Hemophilia	□ 25. Hemophilia/			-			
☐ 9. Cro	hn's Disease	26. Juvenile Diab	etes	☐ 41. Alcohol or	Drug Dependency				
🗖 10. Ga	astric / Peptic Ulcer	27. Diabetes Insu	lin Dependent	☐ 42. Depression	n				
☐ 11. St	troke (Date:)	28. Diabetes Oral	Medication	dication 43. Hepatitis, type A					
☐ 12. Le	eukemia or Melanoma	☐ 29. Heart Attack		44. Muscular [Dystrophy				
☐ 13. Er	mphysema	☐ 30. Coronary Arte	ery Disease	45. Other Hea	rt Disorders				
☐ 14. LU	JPUS	☐ 31. Liver Disorder	S	46. Other Men	tal/Emotional Disorde	ers			
☐ 15. Ba	ack / Spinal Disorder	☐ 32. Congenital Di	sease / Defect	☐ 47. Sexually Transmitted Disease					
☐ 16. Bo	owel / Stomach Disorders	☐ 33. Other Neurolo	ogical Disorders						
💷 17. Lu	ung Disorders	☐ 34. Kidney / Urina	ary Disorders						
7. MEDICAL QUESTIONS									
/. IVILL	7071 <u>2</u> 0.020 110110								
		our dependents had, or he	een treated for cancer?		Yes 1	No			
1) Within	the past 5 years, have you or y explain in Section 8.	our dependents had, or be	een treated for cancer?			No			
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9. AGREEMENT

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 authorize any physician, medical practitioner, hospital, clinic, Veterans Administration facility, other medical or medical-related facility, insurer, re-insurer, health maintenance organization. Medical Information Bureau, Inc., or Consumer Reporting Agency having information available as to diagnosis, treatment, prognosis and plan of first time treatment with respect to any physical or mental condition and/or treatments of me or my covered dependents and any other non-medical information of me or my covered dependents to give to SIHO or their legal representative any and all such information.

I understand the information referenced above and obtained be use of this authorization to be confidential and used by SIHO only to determine eligibility for coverage and eligibility for benefits under an existing policy. Any information obtained will not be released by SIHO to any person or organization except to reinsuring companies (who will treat the information as confidential and limit its use to its specific business), or other persons or organizations performing business or legal service in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize.

I know that I may request to receive a copy of this authorization. I agree that a photographic copy of this authorization shall be as valid as the original. I agree that this authorization shall be valid for two and one half years from the date of this enrollment form/application

10. AUTHORIZATION OF COVERAGE

If you elect coverage/application to the SIHO Health Plan, your signature below will attest to and acknowledge the following:

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 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 (illnesses or injuries for which diagnosis, medical services or treatment was received or for which symptoms occurred which would cause a ordinarily prudent person to seek diagnosis, care, medical services or treatment prior to the effective date).

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 elect to enroll/apply in the SIHO Health Plan	
Signature of Proposed Insured Employee	Date
Signature of Spouse (If applicable)	Date