SIHO INSURANCE SERVICES

INSURANCE APPLICATION
EMPLOYEE APPLICATION

Please return signed application by:
(1) mail to SIHO, 417 Washington St., Columbus, IN 47201, Attn: Membership;
(2) fax to (812) 373-8717; or (3) email to membership.dept@siho.org

This application must be used for new enrollment for groups with 51+ employees with medical underwriting for all current employees and new hires.

1. REASON FOR APPLICATION

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 ☐ Open Enrollment (please mark all that apply)

New and Special Enrollees: identify the qualifying life event (QLE)?

☐ Involuntary Loss of Coverage (*not* failure to pay premium) ☐ Divorce ☐ Other: _____ **Date of QLE:** __/__/ _____

NOTE: If enrolling due to a QLE, proof of QLE (divorce decree, Certificate of Creditable Coverage, Medicaid, etc.) **must** accompany application.

2. PERSONAL INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Social Security #_____ Email Address _____

Race (see codes on next page)_____ Ethnicity (See codes on next page) _____

Home Phone _____ Work Phone _____ Birth Date _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employer_____ Location_____ Job Title _____

Date of Full Time Hire ___/___/___ Date of Rehire ___/___/___ **Avg. Hours Worked:** ☐ less than 30 hrs./wk. ☐ 30+ hrs./wk.

Explanation of Benefit (EOB) notification preference (*please mark all that apply*): ☐ Email ☐ Mail ☐ Apply to all under 18 dependents

3. PLAN SELECTION

Note: Please see your employer if you are unsure about the plan option(s) available to you.

Products	**Deductible Amts.**
Choice	
HSA	
HRA	

☐ **Dependent Life**: Please check for Life Insurance coverage for your dependents (available if employer has elected to offer through SIHO)

Please indicate coverage type for each plan for which you are eligible:

Choose Coverage Type	**Plan Type**
E Employee Only	Medical _____
ES Employee & Spouse	Dental _____
EC Employee & Children	Vision _____
F Employee & Family	

Voluntary Plans (please mark one each):

Dental Plan:
____ Paramount
____ Preferred
____ Standard
____ Value
____ None

Vision Plan:
_____ 12 months/12 months
_____ 12 months/24 months
_____ None

	Last Name	First Name	Social Security #	Height	Weight	Ethnicity *(see codes on next page)*	Race *(see codes on next page)*	Birth Date	Sex F/M	Primary Care Physician	Tobacco User (Y/N)
Self											
Spouse											
Child											
Child											
Child											
Child											
Child											

Race Codes Please select the race that best describes you or your dependent. Please put this number on the race-related questions listed on front.	
Race Code	Race Name
00	Unknown
01	Decline to Report
02	White
03	Black or African American
04	American Indian or Alaska Native
05	Asian
06	Asian Indian
07	Chinese
08	Filipino
09	Japanese
10	Korean
11	Vietnamese
12	Other Asian
13	Native Hawaiian or Other Pacific Islander
14	Native Hawaiian
15	Guamanian or Chamorro
16	Samoan
17	Other Pacific Islander
18	Middle Eastern or North African
19	Another Race Not Listed Above

Ethnicity Codes Please select the ethnicity that best describes you or your dependent. Please put this number on the ethnicity-related questions listed on front.	
Ethnicity Code	Ethnicity Name
00	Unknown
01	Decline to Report
20	Hispanic
21	Not Hispanic
22	Cuban
23	Mexican, Mexican American, Chicano/a
24	Puerto Rican
25	An Ethnicity Not Listed Above

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

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 any <u>OTHER</u> 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 ☐ More dependents

<u>NOTE:</u> You *<u>must</u>* notify SIHO within 30 days of any changes in eligibility, status, or other insurance coverage.

<u>OTHER</u> 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: _____

Policy # (should be listed on card): _____ Effective Date: _____

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. SIHO must receive notice of any changes to beneficiaries to ensure that the change will be effective. If multiple beneficiaries are designated, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) as they survive 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 SSN	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 for its chosen coverage options.

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. 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
☐ Other: _____

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 third-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 QUESTIONNAIRE

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
- ☐ 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, expected delivery date: / /
- ☐ 21. Inpatient, PHP (Partial Hospitalization), or IOP (Intensive Outpatient)
- ☐ 22. Any other medical condition not listed above] =

8. EXPLANATION

Medical Condition #	Which Covered Member (Full Name)	Illness, Condition, or Disease	Date of Diagnosis, Medication, Treatment and Prognosis	Treating Physician's Name

Below, please list all hospitalizations and/or surgical procedures that you or any of your dependents have undergone within the past 3 years. Please also list any future surgical procedures that you and/or any of your dependents reasonably expect to undergo within the next 12 months.

Which Covered Member (Full Name)	Surgical Procedure	Date or Anticipated Date of Surgical Procedure	Physician's Name

Below, please list all medications not disclosed above.

Which Covered Member (Full Name)	Illness, Condition, or Disease	Medication	Physician's Name

9. ENROLLMENT 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 certificate of coverage and group policy issued. 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 provided as a part of the process of confirming eligibility to participate, or that is not otherwise reasonably corrected upon actual or constructive notice to the undersigned or any participant enrolled hereunder and is relied on by SIHO may impact, reduce, delay or void not only a future claim, but the actual or 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 only to the extent that it authorizes the disclosure of health information other than for health plan purposes.

I agree that any benefit payable on my behalf under the SIHO Health Plan 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 employer-sponsored group benefit plan in which I am enrolled until this authorization is revoked by me in writing. I understand that I must be actively working and otherwise satisfy any applicable eligibility criteria outlined in the Certificate of Coverage.

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 Certificate of Coverage and any of SIHO's relevant policies and/or procedures. In fact, all benefits and coverage for my eligible dependents and myself will be provided in accordance with that Certificate and relevant policies and/or procedures. 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 only to the extent that it permits the use or disclosure of health information other than for health plan purposes at any time by giving written notice to SIHO through the employer. 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.

If employer has selected to offer voluntary Group Dental Coverage, it is provided under the Group Dental Insurance Policy insured through SIHO Insurance Services under the Policy (policy No. 112618) issued by Health Resources Inc., Evansville, IN. Group Vision Coverage is provided by EyeMed Vision under the Group Vision Policy insured through SIHO Insurance Services under the Policy (Policy no. 112618) insured by Health Resources Inc., Evansville, IN.]

I understand that unless otherwise required by law, SIHO will provide all required regulatory notices via its member and/or employer portal(s) accessed at www.siho.org. 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, rescission of coverage, denial of claims and confinement in prison.

Unless revoked earlier, this authorization will be valid for as long as I am enrolled in any of my employer's chosen SIHO Health Plan coverage options and for at least seven (7) years after the date that my coverage ends to the extent that it is required for health plan purposes.

☐ I elect to enroll/apply in the above-indicated SIHO Health Plan coverage options

_____ _____

Signature of Proposed Insured Employee or Personal Representative Date

_____

Description of Personal Representative