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 needing underwriting for quotes

1. PERSONAL INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Email Address _____

Home Phone _____ Work Phone _____ Birth Date_____

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

Employer: _____ Location:_____

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

2. Coverage

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

	Last Name	First Name	Height	Weight	Birth Date	Sex F/M	Primary Care Physician	Tobacco User (Y/N)
01 Self								
02 Spouse								
03 Child								
04 Child								
05 Child								
06 Child								
07 Child								

3. 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 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:** _____

4. MEDICAL QUESTIONAIRRE

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

5. 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 medications not disclosed above.

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

6. 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 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 understand that any misrepresentation or omission contained herein provided as a part of the process of confirming eligibility to participate. 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 understand that I must be actively working and otherwise satisfy any applicable eligibility criteria outlined in the Certificate of Coverage.

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 apply for the above SIHO Health Plan coverage

Signature of Proposed Insured Employee or Personal Representative

Date

Description of Personal Representative