CARRIER USE ONLY	Group Number _____ Effective Date _____ Subgroup _____ Class_____

IDAHO SMALL EMPLOYER APPLICATION

Please type or print legibly in black ink and complete all applicable sections.

Use for effective dates after September 22, 2010

SECTION 1—EMPLOYER / EMPLOYMENT INFORMATION

NAME OF EMPLOYER			PHONE NUMBER
ADDRESS	CITY	STATE	ZIP CODE
OCCUPATION	HOURS WORKED PER WEEK	DATE YOU STARTED WORK *(mm/dd/yy)*	

SECTION 2—ENROLLMENT INFORMATON

Are you:
☐ a new applicant ☐ adding dependents

☐ Self only
☐ Self and spouse
☐ Self and dependent(s)
☐ Self, spouse and dependent(s)

Please indicate reason for change in current enrollment below:
☐ Involuntary loss of group coverage ***(CERTIFICATE REQUIRED)***
☐ Marriage ☐ Birth ☐ Adoption
☐ Court order *(copy of court order required)*
☐ Other _____

☐ **Date event occurred**: _____/_____/_____

REQUESTED EFFECTIVE DATE

Current Status:
☐ Actively at work
☐ COBRA participant
☐ Disability
☐ Other _____

SECTION 3—APPLICANT INFORMATION *(EMPLOYEE)*

FIRST NAME	LAST NAME	MIDDLE INITIAL
MAILING ADDRESS *(Street, Route, P.O. Box)*	CITY, STATE, ZIP CODE	COUNTY
HOME OR CELL NUMBER	E-MAIL ADDRESS	

MARITAL STATUS	DATE OF BIRTH	GENDER	HEIGHT	WEIGHT	SOCIAL SECURITY NUMBER* (Required)
☐ Single ☐ Married ☐ Divorced ☐ Other *(explain)*_____		☐ Male ☐ Female			

SECTION 4—DEPENDENT INFORMATION

List all eligible dependents you wish to enroll, including any child who is under the age of 26; or who is medically certified as disabled and dependent on parent for support (copy of certification required). Use extra paper if necessary.

DEPENDENT'S NAMES (first, initial, last)	RELATIONSHIP TO APPLICANT (spouse, child)	DATE OF BIRTH	GENDER	HEIGHT	WEIGHT	SOCIAL SECURITY NUMBER* (Required)
			☐ Male ☐ Female			
			☐ Male ☐ Female			
			☐ Male ☐ Female			
			☐ Male ☐ Female			
			☐ Male ☐ Female			

The Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) requires group health plan insurers to report information that the Dept. of Health and Human Services requires for purposes of coordination of benefits. In order for Medicare to coordinate Medicare payments properly with other insurance benefits, Medicare relies on the collection of both the Social Security Number (or Medicare Health Insurance Claim Numbers) and the Employer Identification Number. Therefore, please provide Social Security Numbers for you and each dependent listed.

If you wish to waive coverage for you and/or any dependents at this time, please complete Section 5—Waiver of Coverage. If you wish to enroll yourself and/or your dependents, please continue to Section 6—Prior Coverage. Note: You do not have to cancel individual coverage if you enroll on this group coverage.

SECTION 5—WAIVER OF COVERAGE (To be completed only if coverage is declined or refused by an eligible employee or dependents.)

I decline all coverage for:
Self (name) _____
Spouse (name) _____
Dependent (name) _____
Dependent (name) _____
Dependent (name) _____
Dependent (name) _____

Reason for declining coverage (check all that apply):
☐ I and/or my dependents currently have other qualifying medical coverage with (name of carrier) _____, through:
☐ my other employer ☐ my spouse's employer ☐ individual policy ☐ Medicare ☐ Medicaid ☐ Tricare ☐ Indian Health Service **OR**
☐ Other reason for declining coverage (please explain) _____

SIGNATURE TO WAIVE**
I have decided to waive coverage as indicated above. I have been given the opportunity to apply for group coverage as offered by the employer. Should I decide to apply for this coverage in the future, I realize and agree any coverage may be subject to additional waiting periods.

****Signature** _____ **Date** _____
(sign only if waiving coverage)

Notice of enrollment rights: If you are declining enrollment for you or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

COMPLETE THE REMAINDER OF THE APPLICATION ONLY IF YOU ARE APPLYING FOR COVERAGE.

SECTION 6A—HEALTH STATEMENT

Please answer each question completely and accurately. Each medical question set forth below applies to each person you listed on this application for whom you wish to obtain coverage, and they apply to both past and present symptoms, conditions, diseases, illnesses, accidental injuries, or deformities ("health conditions"). Coverage under the master group policy will not commence until the application is approved by the insurer's Underwriting Department. No independent producer, agent, or any other person can waive its requirements or is authorized to set forth anything less than a complete and accurate response to each of the questions. The insurer shall not be bound by any attempted waiver of complete answers to the questions set forth below. **If you learn at any time before the application is approved by the insurer that any answer on this application is incomplete or inaccurate or is no longer complete and accurate, you must advise the insurer.**

Answer the questions below YES or NO. Each of the questions must be answered, even if the answer is NO. **Answer a question YES if you or any dependent(s) for whom you want to obtain coverage now has, or at any time in the past has had, or has consulted with a physician or other health care provider concerning the health condition or event specified in that question. IF YOU ANSWER YES TO ANY QUESTION BELOW, PLEASE COMPLETE SECTION 6B.**

RESPOND to the following questions: Yes No

1. Are you, your spouse, or any eligible dependent family member listed on this application, now pregnant? ❒ ❒
   If Yes, due date _____
   Do you anticipate complications? ❒ ❒
   Prior/anticipated multiple births? ❒ ❒
2. **Pregnancy/Fertility Related Treatment:** Are you, your spouse, or any dependent family member being treated for infertility, fertility evaluation or treatment (including medication)? ❒ ❒

WITHIN the past 12 MONTHS has any applicant: Yes No

3. Used any medication or drug? ❒ ❒

WITHIN the past 5 YEARS has any applicant been diagnosed with or treated for any of the following: Yes No

4. **Urinary, bladder, incontinence, kidney or liver conditions or disorders?** Kidney stones, jaundice, nephritis, or any other disorder of the liver, kidneys, or pancreas? ❒ ❒
5. **Neurological disorders:** Recurring headaches, migraines, head injury, epilepsy, seizures, or convulsions or other neurological disorder? ❒ ❒
6. **Metabolic and endocrine conditions or disorders:** Lupus, thyroid disorder, goiter, or any other lymph system disorder ❒ ❒
7. **Eyes, ears, nose, sinus, or throat conditions or disorders** or any other respiratory system disorder including allergies or hay fever? ❒ ❒
8. **Skin conditions or disorders:** Acne, psoriasis, eczema, growths (except warts), cysts, abnormal moles or birthmarks, any other skin disorder? ❒ ❒
9. **Breast conditions or disorders:** breast lumps, fibrocystic breast disease, breast augmentation, or breast reduction? ❒ ❒
10. **Heart conditions or disorders:** Chest pain, high blood pressure, high cholesterol, irregular heartbeat, or any other heart condition? ❒ ❒
11. **Male reproductive conditions or disorders:** Impotence, prostate or testicular disorder, or abnormal PSA or other reproductive disorder? ❒ ❒
12. **Circulatory system conditions or disorders:** Varicose veins, or any other circulatory disorder? ❒ ❒
13. **Sexually transmitted diseases?** ❒ ❒
14. **Female reproductive conditions or disorders:** Irregular bleeding, abnormal Pap smear/test, endometriosis, recurring pelvic pain, or pelvic inflammatory disease or any other disorder of the reproductive system? ❒ ❒
15. **Nervous, mental and behavioral:** Mental health counseling, psychotherapy, depression, stress, anxiety, attention deficit hyperactivity disorder (ADHD), mental health disorder, or chemical imbalance that required consultation or medication? ❒ ❒

WITHIN the past 10 YEARS has any applicant been diagnosed with or treated for any of the following: Yes No

16. **Arthritis or rheumatism?** ❒ ❒
    ❒ Osteoarthritis ❒ Rheumatoid ❒ Other _____
    If Yes, joints affected: _____
17. **Musculoskeletal conditions or disorders:** Ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc, spina bifida, kyphosis, scoliosis, spinal stenosis, or spondylosis or other musculoskeletal disorders? ❒ ❒

WITHIN the past 10 YEARS has any applicant been diagnosed with or treated for any of the following (continued): Yes No

18. **Digestive conditions or disorders:** Ulcers, hernias, chronic diarrhea, diverticulitis, irritable bowel syndrome, reflux, GERD, hemorrhoids, polyps, Crohn's disease, colitis, colostomy or ileostomy, or any other gallbladder, digestive or rectal disorders? ❒ ❒
19. **Alcohol or Drug Use/Abuse:** Alcoholism, drinking problem, convicted of DUI/DWI, drug dependency, abuse, or misuse of prescribed or non-prescribed drugs such as opiates, stimulants, depressants, and/or hallucinogens? ❒ ❒
20. **Eating disorders/obesity treatment:** including bulimia, anorexia, or obesity and any surgical services for obesity? ❒ ❒
21. **Back, neck, bone, joint or spinal disorders:** bone infection, bone or joint disorders (including foot, knee, jaw, fracture, dislocation or joint replacement)? ❒ ❒
22. **Blood conditions or disorders:** Hemophilia, anemia, blood or bleeding disorder? ❒ ❒

HAS any applicant EVER been diagnosed with or treated for any of the following: Yes No

23. **Respiratory conditions or disorders:** Respiratory Syncytial Virus (RSV), reactive airway disease, tuberculosis, asthma, chronic bronchitis, sleep apnea, pleurisy, COPD, sarcoidosis, or emphysema? ❒ ❒
24. **Transplant or implanted device:** Any organ or tissue transplant, pacemaker or other implanted device? ❒ ❒
25. **Nervous, mental and behavioral:** Bipolar affective disorder, manic depression, schizophrenia, chronic organic brain syndrome, attempted suicide, or psychotic disorder? ❒ ❒
26. **Birth defect/congenital abnormalities:** premature birth, development or learning disability, mental impairment, Down syndrome, autism spectrum disorder or physical deformities? ❒ ❒
27. **Heart and circulatory conditions or disorders:** Heart murmur, heart attack, bypass surgery, angioplasty/stent, blood clot, stroke, heart surgery, coronary artery disease, or congestive heart failure? ❒ ❒
28. **Brain/nervous system conditions or disorders:** Multiple sclerosis, polio, stroke, paralysis, muscular dystrophy, cerebral palsy, Lou Gehrig's disease (ALS), Parkinson's disease, Alzheimer's disease, or dementia? ❒ ❒
29. **Diabetes or insulin resistance?** ❒ ❒
    If you have diabetes, is it: ❒ Type 1 ❒ Type 2
30. **Immune system conditions or disorders:** Immune system diseases, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC)? ❒ ❒
31. **Cancer (including skin cancer or melanoma) or tumors?** ❒ ❒
32. **Hospitalization/Surgery:** Has anyone listed on this application been hospitalized or had surgery? ❒ ❒
33. **Any medical conditions not mentioned in the previous questions?** ❒ ❒
    If Yes, list: _____
    _____

OTHER MEDICAL INFORMATION Yes No

34. **Do you have a family doctor?** ❒ ❒
    If Yes, list name: _____

SECTION 6B—HEALTH STATEMENT (If you answered Yes to any question in Section 6A, please complete the information in this section. Use extra paper if necessary.)					
Item #	Person Affected		Name of Disease, Symptom or Condition	Type of Treatment	Complete Recovery? (Y/N)
	Date of Onset (mm/yy)	Last Treated (mm/yy)	Name of Physician and/or Hospital	Medication Name	Frequency/Last Date Taken
Item #	Person Affected		Name of Disease, Symptom or Condition	Type of Treatment	Complete Recovery? (Y/N)
	Date of Onset (mm/yy)	Last Treated (mm/yy)	Name of Physician and/or Hospital	Medication Name	Frequency/Last Date Taken
Item #	Person Affected		Name of Disease, Symptom or Condition	Type of Treatment	Complete Recovery? (Y/N)
	Date of Onset (mm/yy)	Last Treated (mm/yy)	Name of Physician and/or Hospital	Medication Name	Frequency/Last Date Taken
Item #	Person Affected		Name of Disease, Symptom or Condition	Type of Treatment	Complete Recovery? (Y/N)
	Date of Onset (mm/yy)	Last Treated (mm/yy)	Name of Physician and/or Hospital	Medication Name	Frequency/Last Date Taken

List any medications or drugs (that are not listed in previous sections) taken by all applicants within the past 12 months. Use extra paper if necessary.

Patient's Name	Type or Name of Drug	Dosage or Frequency of Use	Date Last Taken or Ongoing	Condition Requiring Medication	Physician's Name

35. Are you or any of your dependents listed on this application currently disabled? .... ☐ Yes ☐ No

Name of disabled person______________________________ Physician's Name and Phone ____

Date of Disability ___________________________________ Physician's Address ____

Nature of Disability ____

36. Has any person listed on this application used a tobacco product during the past 12 months? .... ☐ Yes ☐ No

If Yes, list name(s) ____ Quit date(s) ________________

37. Has surgery, diagnostic testing, medical treatment or follow-up visit been advised (but not yet performed) .... ☐ Yes ☐ No
for anyone on this application? **If Yes**, list person's name and details? ____

____

38. Has any named person incurred medical expenses or claims exceeding $10,000 in the past 24 months? .... ☐ Yes ☐ No

If Yes, give person's name and details: ____

____

39. Are you or any dependent listed on this application covered on Medicare or have received Social Security Disability or Workers' Compensation payments or are now eligible to receive such payments? .... ☐ Yes ☐ No

If Yes, give person's name, specific type and details: ____

____

SECTION 7— CURRENT/PRIOR COVERAGE (For proper crediting of preexisting condition waiting periods AND Coordination of Benefits, please complete the section below. Use extra paper if necessary.)

If any person listed on this application has been covered during the 12 months prior to the requested effective date of this application, with a 63-day or less break in coverage, please complete the following information. Please provide a ***Certificate of Creditable Coverage*** from your prior carrier or other appropriate documents to establish prior creditable coverage. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care insurance so that the carrier can determine whose coverage is primary **(please use additional paper if needed)**.

To reduce the 12-month exclusion period by your creditable coverage, you should give your new carrier a copy of any *Certificates of Creditable Coverage* you have. If you do not have a certificate, but you do have prior health coverage, you should work with your prior plan or insurer to obtain evidence of coverage. There are also other ways that you can show you have creditable coverage; i.e., pay stubs or EOBs. Please contact your new carrier if you need help demonstrating creditable coverage.

Other Carrier Information: Carrier Name, Policy Number, Phone Number	Policyholder Name	Names of Covered Members: Self and Dependent(s)	Coverage Start Date (mm/dd/yy)	Coverage End Date (mm/dd/yy)	Type of Coverage	Will this coverage continue?	Is your child eligible for other employer sponsored coverage through his/her employer or spouse?
					☐ Medical ☐ Dental	☐ Yes ☐ No	☐ Yes ☐ No
					☐ Medical ☐ Dental	☐ Yes ☐ No	☐ Yes ☐ No
					☐ Medical ☐ Dental	☐ Yes ☐ No	☐ Yes ☐ No
					☐ Medical ☐ Dental	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 8—AFFIRMATION

I affirm the answers given in this "Idaho Small Employer Application" are complete and correct. I am providing these answers as part of the application procedure required by this insurance carrier to enroll in its insurance coverage. I understand that the insurance carrier will rely on each answer in making its rating determination. I understand if this application contains any material misstatements or omissions, the insurance carrier may, within the first 24 months of coverage, take any other legal action available by law. I will promptly inform the insurance carrier in writing if anything happens before my coverage takes effect that makes any answer in the "Idaho Small Employer Application" incomplete or incorrect. I understand that a twelve month waiting period for coverage of preexisting conditions may apply. I understand and agree no coverage shall be in force until approved by the insurance carrier. Coverage will be in force as of the effective date pursuant to the terms of the plan/contract.

SECTION 9—STATEMENT OF UNDERSTANDING

By signing this application, I represent that all my answers are complete and accurate and that I understand and agree to the following conditions:

- **No independent producer, agent or employee of the insurance carrier, or of my employer, can change any part of this application or waive the requirement that I answer all questions completely and accurately.**
- **The insurance carrier may terminate or rescind an employer's group coverage for any misrepresentation, omission of fact by, concerning, or on behalf of any applicant that was or would have been material to the insurance carrier's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim.**
- **As proof of status of employment, I authorize my employer to release to the insurance carrier appropriate documents, including but not limited to W-2 Wage and Tax Statements and other wage and tax summaries or forms.**
- **Coverage for me and any eligible persons named on this application will begin on the effective date pursuant to the terms of the plan/contract.**
- **I agree to abide by the terms of the group's master policy/member certificate, which sets forth all of the terms and conditions of my coverage. No agent or other person can change the terms of the master contract, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of the insurance carrier.**
- **I understand that this application will become part of the contract between the insurance carrier and my employer.**
- **I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.**
- **NOTICE OF PREEXISTING CONDITION EXCLUSION: This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a specified period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. This preexisting condition exclusion does not apply to pregnancy nor to individuals under the age of 19 years beginning upon the Employer Group renewal on or after September 23, 2010, as provided in the Patient Protections and Affordable Care Act (PPACA).**

  This exclusion may last up to 12 months from your first day of coverage or, if you were in a waiting period from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is considered creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days.

SECTION 10—ACKNOWLEDGEMENT

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the enrollment form) for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.

Health information requested or disclosed may be related to treatment or services performed by:

- **A physician, dentist, pharmacist or other physical or behavioral health care practitioner;**
- **A clinic, hospital, long-term care or other medical facility;**
- **Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or;**
- **An insurance carrier or group health plan.**

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

Signature of Employee _____ **Date** _____

Signature of Spouse _____ **Date** _____
(if applying for coverage)