

Instructions: Do Not Type. You, the employee, must complete the application in your own handwriting. You are solely responsible for its accuracy and completeness. All questions must be answered in full or the application may be returned to you resulting in a delay. Print clearly using ink. Typed applications will not be accepted.

Benefits

- | | |
|---|---|
| <input type="checkbox"/> Premier PPO Plan | <input type="checkbox"/> Premier POS Plan |
| <input type="checkbox"/> Classic PPO Plan | <input type="checkbox"/> Classic POS Plan |
| <input type="checkbox"/> Value PPO Plan | <input type="checkbox"/> Value POS Plan |

Effective Date
Group #
Underwriter

Employee Information *(Must be completed by employee)*

- Employee enrollment COBRA Qualified Beneficiary

Last Name		First Name		MI	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	
Home Address (P.O. Box not acceptable unless rural P.O. Box)				Apt #	Home Phone #	Work Phone #
City			State	Zip	Applicant/Spouse Maiden Name	
Employer Name			Occupation/Job Title			Hire Date <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time

Employee/Dependent Information *(List yourself and only those eligible dependents who are enrolling.)*

If dependent child is not you or your spouse's birth or legally adopted child, please explain why the child is a dependent.

Please don't forget to provide the Social Security Number of dependents and last name if it differs from the subscriber's last name.

Sex (M/F)	Last Name	First Name	MI	Soc. Sec No.	Height	Weight	Student/Disabled (Y/N)	Birthdate MM/DD/YY	PCP Site Code	Primary Care Practice (POS Only)
	Employee									
	Spouse									

Coverage Declination *(To be completed if coverage is declined or refused by an eligible employee and/or their dependent(s).)*

A. Coverage declined for: Myself Spouse Dependent(s) Spouse and dependent(s)

B. Reason for declining coverage *(check one)*:

- | | |
|--|--|
| <input type="checkbox"/> Covered by spouse's group coverage—Carrier Name and I.D. #: _____ | <input type="checkbox"/> Covered by Champus or Champva |
| <input type="checkbox"/> Spouse covered by employer's group medical coverage—Carrier Name: _____ | <input type="checkbox"/> Medicare |
| <input type="checkbox"/> Enrolled in any other insurance carrier plan —Carrier Name: _____ | <input type="checkbox"/> Other: _____ |

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given that chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. **I UNDERSTAND THAT BY DECLINING THIS GROUP MEDICAL COVERAGE, MY DEPENDENTS AND I WILL BE REQUIRED TO WAIT UNTIL THE NEXT OPEN ENROLLMENT PERIOD, IF ANY, TO ENROLL IN THIS GROUP MEDICAL COVERAGE.**

Sign only if declining coverage

Signature only if declining coverage for employee and/or dependent

Date (MM/DD/YYYY)

Authorization *(The following authorization is to be signed by ALL EMPLOYEES applying for coverage)*

I AGREE: All information on this form and the attached health questionnaire is correct and true. I understand that it is the basis on which premiums may be determined under the plan. I further authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan. I certify that I am working at the employer's place of business in permanent employment at least 30 hours a week. Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy being rescinded. **I ACKNOWLEDGE THAT I am applying for Preferred Provider Organization (PPO) or Coordinated Care Preferred Provider Organization (POS) coverage: I understand that I am responsible for a greater portion of the cost of my covered medical costs when I use a non-participating provider or, in the case of POS, do not have my care coordinated by my primary care physician. I understand that if I or one of my dependents receive medically necessary covered services from a non-participating provider or a primary care physician does not coordinate care, HealthAssurance will cover only the lower level benefits set forth in the applicable certificate of insurance and I will be responsible for payment of any amount not covered by HealthAssurance. I understand that this is an application for health care coverage and that my coverage will not become effective prior to the date that HealthAssurance notifies my employer that coverage is effective. **AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION.** I authorize any insurance company, physician, hospital, clinic, health care provider or other organization, institution or person having records or knowledge of anyone listed on this application to give HealthAssurance or its designated agent any and all records pertaining to any medical history, services or treatment provided to anyone on this application for purposes of review, investigation or evaluation of coverage. This authorization becomes immediately effective and shall remain in effect as long as necessary to permit evaluation of this application or to process claims. A photocopy of this authorization is valid as the original. I, the applicant, acknowledge that I have read and understand this Application in its entirety.**

Signature of Employee

Date (MM/DD/YYYY)

Signature of Employee's Spouse (if applying for coverage)

Date (MM/DD/YYYY)

Health Questionnaire for Groups with 2-20 Employees

Health history of you and your family (including information about family members you wish to cover)— Has any person listed on this application ever had, consulted for, sought treatment, had treatment recommended, received treatment, been surgically treated or been hospitalized for any of the following conditions: *(Please answer Yes or No. Incomplete applications will be returned to you for completion which may delay the effective date of your coverage.)*

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|---|--|
| <p>1. Heart attack, heart murmur, stroke, chest pain, high blood pressure*, anemia, varicose veins, or any other disorder of the heart, blood, blood vessels, hyperlipemia or arteriosclerosis, high cholesterol* or diabetes*? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Ulcer, colitis, gall stone, hernia or any other disorder of the stomach, intestines, rectum, gall bladder, or liver? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Cancer, cyst, or tumor? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Disorder of the kidneys, blood or albumin, thyroid glands, diabetes, venereal disease or any related eye disorders, urinary systems, male or female organs, or menstrual dysfunction? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Tuberculosis, asthma, hay fever, adenoids, pleurisy or any other kind of disorder of the lungs or respiratory system? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Epilepsy, fainting spells, mental or nervous condition, paralysis or any other disorder of the brain or nervous system? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
If epileptic, date of last seizure: _____</p> <p>7. Arthritis, rheumatic fever, back trouble, or any other disorder of the joints, muscles, or bones? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>8. Any physical deformity or defect? Any serious bodily injury, fracture, concussion, burn and/or congenital problems? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Any immune deficiency disorder, HIV, AIDS, or AIDS-related complex? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Within the last five years, had an X-ray, electrocardiogram, cardiovascular gram, or any laboratory test or study? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Within the last 12 months, taken medicine as prescribed by a physician or other health practitioner? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Been treated for alcoholism or other drug or substance abuse or been advised to seek treatment for the same? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Is any female to be covered currently pregnant? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, Due Date (Month): _____</p> <p>13a. Is any male listed on this application expecting a child with anyone, even if the mother is not listed on this application? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Any history of pregnancy complication? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
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* Please provide the last three readings below.

If you answered "Yes" to any of the questions above, you must complete the following. Please explain and provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked in all the preceding boxes. Please give details below on the last doctor visit and/or physical examination for ALL family members listed regardless of date or reason. *(Insert additional sheets if necessary.)*

Question #	Name of family member (As identified on physician's record)	Name of Hospital, Clinic, or person providing care	Phone #
Date of onset/treatment (Month/Year)	Date Ended <input type="checkbox"/> Still under treatment	Address	Suite #
Name of Condition(s)/Illnesses Treated		City, State, Zip Code	
Treatment Rendered		Medication (if taken)/Date Prescribed/Dosage	
Blood Pressure: #1 #2 #3		Blood Sugar: #1 #2 #3	
Cholesterol: #1 #2 #3			

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Blood Pressure: #1 #2 #3		Blood Sugar: #1 #2 #3	
Cholesterol: #1 #2 #3			

Other Medical Coverage for ALL Enrolling Employees and Dependents *(All questions must be answered.)*

- A. Do any persons on this application intend to continue other group coverage if this application is accepted? _____ Yes No
If yes, Name of person: _____ Insurance Company: _____
- B. Does any person applying for coverage have health insurance coverage: _____ Yes No
If yes, Applicant/family member(s) name: _____ Type of continuous coverage Group Individual Other
Insurance Company: _____ Date coverage began: _____ Date ended: _____
- C. Does any person applying for coverage currently have Dental Insurance Coverage: Type _____
Insurance Company: _____ Date coverage began: _____ Date ended: _____
- D. Is any person applying for coverage eligible for Medicare? _____ Yes No

Any person who knowing and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.