Small Group Enrollment Application

Requested Effective Date

(subject to insurer approval) ____________________________

Group Number ____________________________

❏ PPO ❏ Traditional ❏ Managed Care

❏ HSA PPO ❏ HSA POS

Please complete *each* section of this application in ink.

Applicant Information (Employee)

Your Name (first, initial, last)	Social Security Number / /	Blue Cross Identification No. (if currently enrolled)	Marital Status ❏ Single ❏ Divorced ❏ Married ❏ Widowed
Home Address (street or route)	City, State, Zip Code		County
Name of Employer	Date Employed Full-time (mm/dd/yy) / /	Occupation	Phone Number ( )	Email Address

Family Member Information *(If you choose not to enroll all your eligible family members, you must complete a waiver form.)*

List all family members you wish to enroll, including any unmarried child who is under age 21; or who is under age 25, a full-time student and financially dependent upon you; or who is medically certified as disabled and dependent upon you for support (copy of certification required).

For Managed Care Plans Only

	Social Security Number	Relationship (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy)	Height	Weight		Name of Primary Care Physician (PCP) (For the highest benefit level, you must select a PCP)	Existing Patient of PCP?	*Office Use Only PCP*
Applicant/Employee		SELF				❏ Male ❏ Female		❏ Yes ❏ No	
Family Member's Name (first, initial, last)	/ /		/ /			❏ Male ❏ Female		❏ Yes ❏ No	
Full Time Student ❏ Yes ❏ No	Name of school if student is over age 21								
Family Member's Name (first, initial, last)	/ /		/ /			❏ Male ❏ Female		❏ Yes ❏ No	
Full Time Student ❏ Yes ❏ No	Name of school if student is over age 21								
Family Member's Name (first, initial, last)	/ /		/ /			❏ Male ❏ Female		❏ Yes ❏ No	
Full Time Student ❏ Yes ❏ No	Name of school if student is over age 21								
Family Member's Name (first, initial, last)	/ /		/ /			❏ Male ❏ Female		❏ Yes ❏ No	
Full Time Student ❏ Yes ❏ No	Name of school if student is over age 21								

Please complete the health statement on the following pages and sign this application.

FOR OFFICE USE ONLY

Group Number	Subgroup	HIPAA			Effective Date	Plan ID			Class	Reason Code
		Credit Days	Start	End		M	D	V		

3000 E. Pine Ave. • Meridian, Idaho 83642 • (208) 345-4550

***Mailing Address*: P.O. Box 7408 • Boise, ID 83707-1408**

Auditor __________

Do you or any of your family members have other medical and/or dental coverage? ❑ YES ❑ NO

Coordinating your insurance benefits could reduce the amount you owe a provider.

Prior and/or Current Coverage Information

(Please complete the information below to receive accurate credit for your prior waiting periods.)

Is any person listed on this application now covered, or has he or she been covered, by any other health insurance, including Medicare, Medicaid, or other Blue Cross of Idaho policy during the 12 months prior to the requested effective date of this application (excluding any employee's probationary period?) ❑ Yes ❑ No

If **YES**, further information may be requested to maximize your benefits. Please complete all information below for **each** person listed on this application.

Name	Name of Carrier	Policy Number	Type of Policy (Group or Individual)	Date of Policy		Will Current Policy Continue?
				Start Date (mm/dd/yy)	End Date (mm/dd/yy)	
Employee				/ /	/ /	❑ Yes ❑ No
Spouse				/ /	/ /	❑ Yes ❑ No
Child				/ /	/ /	❑ Yes ❑ No
Child				/ /	/ /	❑ Yes ❑ No
Child				/ /	/ /	❑ Yes ❑ No

(Please use extra paper if necessary.)

If any person listed on this application is covered by Medicare, please complete the following:

_______________ *Name*

_______________ *Medicare Beneficiary Number*

_______________ *Reason for Medicare Entitlement (age, disability or ESRD)*

	Part A	*Part B*
Date of Medicare Entitlement	____/____/____ *mm dd yy*	____/____/____ *mm dd yy*

- If you have had other coverage with another carrier within 63 days (excluding any employee's probationary period) of this request, please attach a copy of your **Certificate of Coverage**; this will ensure proper credit for any preexisting conditions, if applicable, which can be obtained from your current or prior carrier.

Type of Enrollment

Enrollment Coverage

(If your group has dental coverage, your medical and dental enrollment will be the same) (check one)

❑ Self only
❑ Self, spouse and two or more children
❑ Self and spouse
❑ Self and one child
❑ Self, spouse and one child
❑ Self and two or more children

Change Request

Change current enrollment because of the following event:

❑ Marriage ❑ Divorce ❑ Birth ❑ Involuntary loss of coverage ❑ Death

❑ Court order (copy of court order required)

Other _______________

Date event occurred ____/____/____ mm dd yy

Disability Information

Are you or any of your dependents currently disabled? ❑ YES ❑ NO

_______________ *Name of Disabled Person*

_______________ *Date of Disability*

_______________ *Nature of Disability*

_______________ *Physician's Name* *Physician's Phone Number*

_______________ *Physician's Address*

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"). Answer each question completely and accurately. 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 questions 1 through 47 **YES** or **NO. Each of the questions must be answered, even if the answer is NO.** Answer a question **YES** if you or any family member 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. Do not leave any question unmarked.

MEDICAL HISTORY

Question	YES	NO
1. Are you, or any family member, whether or not listed on this application, now pregnant?	❑	❑
2. Positive test for HIV (human immunodeficiency virus) infection	❑	❑
3. Acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC)	❑	❑
4. Alcoholism, drinking condition, or drug abuse	❑	❑
5. Allergies or hay fever	❑	❑
6. Anemia or blood disorder	❑	❑
7. Arthritis or rheumatism		
Osteoarthritis	❑	❑
Rheumatoid	❑	❑
8. Asthma or chronic bronchitis	❑	❑
9. Attempted suicide	❑	❑
10. Back or joint condition	❑	❑
11. Bladder or kidney condition	❑	❑
12. Bodily deformity	❑	❑
13. Bone infection	❑	❑
14. Breast disorder or fibrocystic breast disease	❑	❑
15. Cancer	❑	❑
If skin, type________________		
16. Colon or intestinal condition	❑	❑
17. Complications of pregnancy	❑	❑
18. Congenital disease/defect or mental retardation	❑	❑
19. Depression	❑	❑
20. Diabetes	❑	❑
21. Disorders of the female reproductive organs	❑	❑
22. Disorders of the male reproductive organs including the prostate	❑	❑
23. Dizziness or headaches	❑	❑
24. Epilepsy or seizure disorder	❑	❑
25. Eye, ear, nose, or throat condition	❑	❑
26. Gallstones or gall bladder condition	❑	❑
27. Heart or cardiovascular condition	❑	❑
28. Hemorrhoids or rectal condition	❑	❑
29. Hernia or rupture	❑	❑
30. High blood pressure If yes, last reading	❑	❑
31. Injuries or accidents	❑	❑
If broken bones, are there pins or hardware?	❑	❑
32. Liver condition, cirrhosis, or hepatitis	❑	❑
If hepatitis, type______________		
33. Lung condition or emphysema	❑	❑
34. Mental or nervous conditions	❑	❑
35. Neurological conditions	❑	❑
36. Phlebitis	❑	❑
37. Polio	❑	❑
38. Sinus condition	❑	❑
39. Skin conditions	❑	❑
40. Stomach conditions or ulcers	❑	❑
41. Stroke or paralysis	❑	❑
42. Thyroid or pituitary condition	❑	❑
43. Tuberculosis	❑	❑
44. Tumor, growth, or cyst	❑	❑
45. Ulcerative colitis	❑	❑
46. Varicose veins	❑	❑
47. Has anyone who resides in your household smoked tobacco during the twelve months preceding this application?	❑	❑

If you checked YES to any question above, please provide details below *(please use extra paper if necessary)*:

Item No.	Person Affected	Mo./ Year	Name of Disease, Symptom, or Condition – Include Type of Treatment	Name of Hospital and Number of Days	Date Last Treated	Was Recovery Complete?	Drugs – Include Type or Name	Name of Physician

*If the answer to **any** of the following questions is **YES ,** please give the details. Include the person's name and, where applicable, the nature of the health condition and reason for the consultation, the advice and results, the physician's name, and dates of the consultation, unless explained elsewhere on this application.*

Have you or any family members listed on this application:

Suffered from or now suffer from any chronic or recurring ailments, illnesses, or other departures from good health, regardless of whether a physician or other health care provider was consulted? ❑ **YES** ❑ **NO** If yes, explain and give details.

____

____

Received a prescription for medication from a physician or used any prescribed
medication during the last 12 months? ❑ **YES** ❑ **NO** If yes, give details (type or name, dosage, strength and duration).

____

____

Been advised to have any surgical operation(s) or diagnostic testing that has *not yet* been performed? ❑ **YES** ❑ **NO** If yes, explain and give details.

____

____

Ever been refused or issued restricted health insurance coverage or been offered a program with a restrictive rider attached? ❑ **YES** ❑ **NO** If yes, explain and give details.

____

____

Received Social Security Disability or Workers' Compensation payments or are now eligible to receive such payments? ❑ **YES** ❑ **NO** If yes, explain and give details.

____

____

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:

- If I decline to enroll any eligible family member on this application, or a newly-eligible family member at a later date, I must complete, sign and return to the insurer the *Employee's Waiver of Health Care Coverage* form.
- No independent producer, agent or employee of the insurer, or of my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The insurer may, at its discretion, request supplemental information from me, any family member listed on this application or any health care provider.
- On behalf of myself and all enrolled family members, I understand if the insurer discovers any intentional misrepresentation, omission or concealment of fact in obtaining coverage that was or would have been material to the insurer's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim, the insurer may take action against my employer, including but not limited to increasing premiums.
- If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by the insurer.
- I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time 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. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Notice of Privacy Practices that is available at ***www.bcidaho.com***.
- As proof of status of employment, I authorize my employer to release to the insurer appropriate documents, including but not limited to, W-2 Wage and Tax Statements and other wage and tax summaries or forms.
- Preexisting condition waiting period: There are no benefits available under this policy for services, supplies, drugs or other charges that are provided within 12 months after an insured's enrollment date for any preexisting condition.

  A preexisting condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the enrollment date. A pregnancy existing on the enrollment date is not a preexisting condition under this policy. Genetic information shall not be considered as a preexisting condition in the absence of a diagnosis of the condition related to such information.

  In certain circumstances, qualifying previous coverage may be credited toward the preexisting condition waiting period.
- If you have had group or individual health coverage or a government health care program for at least 12 months, you are entitled to receive a Certificate of Creditable Coverage from your previous employer or insurance company. This document will state the effective date of prior coverage and the termination date of coverage for you and any covered dependents. Your previous employer or insurance company will furnish you this certificate upon request. If you need assistance in obtaining a certificate, your current employer or Blue Cross of Idaho can assist you.
- My employer's master group policy is the document that sets forth all terms of my coverage, and no independent producer, agent or other person can change the terms of the master group policy, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of the insurer.
- I agree that a facsimile or photocopy of my signature will serve the same as an original.
- I understand that this application will become part of the contract between the insurer and my employer.
- **I affirm that 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.**

X ____

Applicant's Signature *Date*