GROUP INFORMATION	Group Number _____ Effective Date _____ Subgroup _____ Class _____

IDAHO SMALL EMPLOYER APPLICATION
FOR ENROLLMENT OUTSIDE OF THE IDAHO EXCHANGE

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

SECTION 1 EMPLOYER/EMPLOYMENT INFORMATION

1. Name of Employer			2. Phone Number ( )
3. Address	4. City	5. State	6. Zip Code
7. Occupation	8. Hours Worked Per Week	9. Date You Started Work *(mm/dd/yyyy)*	

SECTION 2 APPLICANT INFORMATION (Employee)

1. **Legal** First Name, Middle Name, Last Name *(and suffix, if applicable)*

2. Mailing Address *(Street, Route, P.O. Box)*

3. City	4. State	5. Zip Code	6. County
7. Preferred **Daytime** Phone Number	8. Email Address		9. Date of Birth *(mm/dd/yyyy)*
10. Gender ☐ Male ☐ Female	11. Social Security Number **(required)**	12. Marital Status ☐ Single ☐ Married ☐ Other _____	

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 complete all sections except Section 5.

SECTION 3 ENROLLMENT INFORMATION (check all that apply)

1. Are you: ☐ A new applicant ☐ Adding dependents ☐ Enrolling during your employer's open enrollment
2. If you are enrolling ***outside*** of your employer's open enrollment or adding dependents, what is the reason *(documentation may be required)*? ☐ Marriage ☐ Divorce ☐ Birth ☐ Adoption ☐ Involuntary loss of ***employer*** coverage ☐ Involuntary loss of ***individual*** coverage ☐ Involuntary loss of Medicaid ☐ Court order *(copy of court order required)* ☐ Other _____
   Date of event *(mm/dd/yyyy)* _____
3. Type of enrollment:
   ☐ Self only ☐ Self and **legal** spouse ☐ Self and dependent(s) ☐ Self, **legal** spouse and dependent(s)
4. Current employment status:
   ☐ Actively at work ☐ COBRA participant ☐ Disability ☐ Other _____
5. Requested effective date *(subject to approval)*: *(mm/dd/yyyy)* _____

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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). If you have more dependents to include, make a copy of this page and attach.)

Dependent 1

1. **Legal** First Name, Middle Name, Last Name *(and suffix, if applicable)*
2. Relationship
   ☐ L**egal** spouse ☐ Child ☐ Step-child
   ☐ Other _____
3. Gender
   ☐ Male ☐ Female
4. Date of Birth *(mm/dd/yyyy)*
5. Social Security Number **(required)**
6. Does dependent 1 live at the same address as you? ☐ Yes ☐ No

Dependent 2

1. **Legal** First Name, Middle Name, Last Name *(and suffix, if applicable)*
2. Relationship
   ☐ L**egal** spouse ☐ Child ☐ Step-child
   ☐ Other _____
3. Gender
   ☐ Male ☐ Female
4. Date of Birth *(mm/dd/yyyy)*
5. Social Security Number **(required)**
6. Does dependent 2 live at the same address as you? ☐ Yes ☐ No

Dependent 3

1. **Legal** First Name, Middle Name, Last Name *(and suffix, if applicable)*
2. Relationship
   ☐ L**egal** spouse ☐ Child ☐ Step-child
   ☐ Other _____
3. Gender
   ☐ Male ☐ Female
4. Date of Birth *(mm/dd/yyyy)*
5. Social Security Number **(required)**
6. Does dependent 3 live at the same address as you? ☐ Yes ☐ No

Dependent 4

1. **Legal** First Name, Middle Name, Last Name *(and suffix, if applicable)*
2. Relationship
   ☐ L**egal** spouse ☐ Child ☐ Step-child
   ☐ Other _____
3. Gender
   ☐ Male ☐ Female
4. Date of Birth *(mm/dd/yyyy)*
5. Social Security Number **(required)**
6. Does dependent 4 live at the same address as you? ☐ Yes ☐ No

Dependent 5

1. **Legal** First Name, Middle Name, Last Name *(and suffix, if applicable)*
2. Relationship
   ☐ L**egal** spouse ☐ Child ☐ Step-child
   ☐ Other _____
3. Gender
   ☐ Male ☐ Female
4. Date of Birth *(mm/dd/yyyy)*
5. Social Security Number **(required)**
6. Does dependent 5 live at the same address as you? ☐ Yes ☐ No

Dependent 6

1. **Legal** First Name, Middle Name, Last Name *(and suffix, if applicable)*
2. Relationship
   ☐ L**egal** spouse ☐ Child ☐ Step-child
   ☐ Other _____
3. Gender
   ☐ Male ☐ Female
4. Date of Birth *(mm/dd/yyyy)*
5. Social Security Number **(required)**
6. Does dependent 6 live at the same address as you? ☐ Yes ☐ No

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

1. I decline coverage for:
   Self (name) _____ Dependent (name) _____
   Spouse (name) _____ Dependent (name) _____
   Dependent (name) _____ Dependent (name) _____
2. 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 Services **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 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 probationary waiting periods.

****Signature** _____ **Date** _____
(sign only if waiving coverage) *mm/dd/yyyy*

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.

SECTION 6 OTHER COVERAGE INFORMATION *(Please complete the section below if you have other coverage that will remain in effect. If you have more policies to include, make a copy of this page and attach.)*

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 insurance carrier can determine whose coverage is primary.

Other Policy

1. Other Insurance Carrier Information: Insurance Carrier Name, Policy Number, Phone Number

2. Policy Holder Name		3. Names of Covered Members	
4. Types of Coverage *(check all that apply)* ☐ Group ☐ Dental ☐ Individual ☐ Vision ☐ Medicare	5. Coverage Start Date *mm/dd/yyyy*	6. Is this coverage terminating? ☐ Yes (complete #7) ☐ No	7. Coverage End Date *mm/dd/yyyy*

SECTION 7 OTHER INFORMATION

1. Are you or any of your dependents listed on this application currently disabled? ☐ No ☐ Yes
   Name of disabled person _____ Physician's name and phone _____
   Date of disability _____ Physician's address _____
   Nature of disability_____
2. Are you or any dependent listed on this application covered on Medicare or have received Social Security Disability or Worker's Compensation payments or are now eligible to receive such payments? ☐ No ☐ Yes
   If yes, give person's name, specific type and details: _____
   _____
3. Has any person listed on this application used a tobacco product on average four or more times a week within no longer than the past six Months (anyone age 18 or older)? ☐ No ☐ Yes **If yes**, list names below:
   1. _____ 3. _____
   2. _____ 4. _____

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SECTION 8 AFFIRMATION

I affirm the answers 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 determination to extend coverage and to determine the type of coverage offered. I understand if I have made any misstatement or omission in this application, the insurance carrier may take any action available by law, including but not limited to, retroactive adjustment of premiums or claims. Further, I understand that any fraud or intentional misrepresentation of material fact in my completion of this application is cause for retroactive termination of coverage by the insurance carrier and/or other action available at law. I will promptly inform the insurance carrier in writing if anything happens before my coverage takes effect that makes an answer on this application incomplete or incorrect. Following receipt of a fully-executed application, coverage will be in force as of the effective date determined by the insurance carrier under applicable law.

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 intentional 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 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.

SECTION 10 PREEXISTING CONDITION WAITING PERIOD

NOTICE OF PREEXISTING CONDITION LANGUAGE: I understand that, until the first plan year beginning January 1, 2014 or later, a waiting period for preexisting conditions may apply. 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 begins on the day before the waiting period began. 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 11 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 *(mm/dd/yyyy)* _____

Signature of Spouse _____ Date *(mm/dd/yyyy)* _____
(if applying for coverage)

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