- OFFICE USE ONLY -	
POLICY NUMBER	POLICY EFF. DATE

Idaho Small Employer Application

Type of Enrollment:
☑ New Applicant
☐ Adding Dependents

Requested effective date: _____
(Pursuant to terms of the contract)

Change current enrollment because of the following event:
☐ Marriage ☐ Divorce ☐ Birth
☐ Death ☐ Adoption
☐ Court order (copy of court order required)
☐ Other _____
Date event occurred ___/___/___ (MM DD YY)

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

EMPLOYER INFORMATION

Employer				Group No.
Address	City	State	Zip	Phone No.

EMPLOYEE INFORMATION

Employee	Occupation	☐ Single ☐ Married ☐ Other _____
Address	City / State / Zip	Phone No.

Date of Full-Time Employment ___/___/___ (MM DD YY)	Average Number of Hours Worked Per Week	Current Status: ☐ At Work ☐ Disability ☐ COBRA ☐ Other _____

List all family members you wish to enroll, including any unmarried child who is under age 19; or who is under age 23, 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).

Self and Dependent's Names (First, Initial, Last)	Relationship to Applicant	Weight	Height	Sex	Date of Birth	Dependent Claimed on U.S. Income Tax	Social Security Number
Employee	Self					☐ Yes ☐ No	
Spouse						☐ Yes ☐ No	
Child						☐ Yes ☐ No	
Child						☐ Yes ☐ No	
Child						☐ Yes ☐ No	
Child						☐ Yes ☐ No	

Are you enrolling every eligible dependent? ☑ Yes ☐ No Complete the waiver section on the back of this application for any family members that are not to be insured

CURRENT / PRIOR COVERAGE INFORMATION

Please indicate for **EACH** person listed on this application any health insurance coverage (including Medicare or Medicaid) in effect within 12 months prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health insurance coverage was in effect within the past 12 months, please indicate **NONE**. **If you have had coverage with another carrier within 63 days (excluding employee's probationary period) of this request a "Certificate of Health Plan Coverage" or proof of existing coverage must be provided to accurately credit your waiting periods.**

Applicant's Name	Insurance Carrier (Policy # and Phone #)	Dates of Coverage MONTH / DAY / YEAR FROM	Dates of Coverage TO	Will continue any current coverage?	Type of Coverage Group Individual Dental Medical	For Office Use Only
Employee		MM / DD / YY	MM / DD / YY	☐ Yes ☐ No	❑ Group ❑ Individual ❑ Dental ❑ Medical	
Spouse				☐ Yes ☐ No	❑ Group ❑ Individual ❑ Dental ❑ Medical	
Child				☐ Yes ☐ No	❑ Group ❑ Individual ❑ Dental ❑ Medical	
Child				☐ Yes ☐ No	❑ Group ❑ Individual ❑ Dental ❑ Medical	
Child				☐ Yes ☐ No	❑ Group ❑ Individual ❑ Dental ❑ Medical	
Child				☐ Yes ☐ No	❑ Group ❑ Individual ❑ Dental ❑ Medical	

If your coverage is terminated, please state reason: _____

HEALTH STATEMENT

INSTRUCTIONS:

1.) Each medical question below applies to all persons listed on this application who desire coverage.
2.) The questions apply to both past and present symptoms, conditions, diseases, illnesses, accidental injuries, or deformities (health conditions).
3.) Answer the questions below either Yes or No. Each of the questions must be answered. Answer Yes to a question if you or any family member for whom you want to obtain coverage now has, or at any time in the past has experienced or received care for the health condition or event specified in that question.
4.) Answer each question accurately and explain any conditions you answered yes to in the boxes provided below.
5). Do not leave any question unmarked.
6.) No agent or any other person can waive these requirements or is authorized to set forth anything less than a complete and accurate response to each of the questions. The Insurance Carrier shall not be bound by an attempted waiver of complete answers to the questions set forth below.
7.) If you learn at any time before approval of coverage by the Insurance Carrier that any answer on this application is incomplete, you must advise the Insurance Carrier.

	Yes	No
1. Are you, your spouse, any eligible dependent child, or mate, whether or not listed on this application, now pregnant?	☐	☐
Due Date _____		
Complications anticipated?	☐	☐
Prior or anticipated multiple births?	☐	☐
2. Positive test for HIV (Human Immunodeficiency Virus) infection	☐	☐
3. Acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC)	☐	☐
4. Alcoholism, drinking problem, drug abuse, or convicted of DUI/DWI	☐	☐
5. Allergies or Hay Fever	☐	☐
6. Anemia or blood condition	☐	☐
7. Arthritis or rheumatism	☐	☐
8. Asthma or chronic bronchitis	☐	☐
9. Attempted suicide	☐	☐
10. Back or joint condition	☐	☐
11. Bladder or kidney condition	☐	☐
12. Bodily deformity or congenital disease/defect	☐	☐
13. Bone infection	☐	☐
14. Breast condition or fibrocystic breast disease	☐	☐
15. Cancer	☐	☐
16. Colon / Bowel / Rectal condition	☐	☐
17. Depression	☐	☐
18. Diabetes	☐	☐
19. Disorders of the female reproductive organs/Infertility	☐	☐
20. Disorders of the male reproductive organs including the prostate/infertility	☐	☐
21. Dizziness or headaches	☐	☐
22. Epilepsy or seizure condition	☐	☐
23. Eye, ear, nose or throat condition	☐	☐
24. Gallstone or gall bladder condition	☐	☐
25. Heart or cardiovascular condition	☐	☐
26. Hernia or rupture	☐	☐
27. High blood pressure	☐	☐
If yes, last reading and date _____		
28. High cholesterol	☐	☐
If yes, last reading and date _____		
29. Liver conditions, cirrhosis or hepatitis	☐	☐
30. Lung conditions or emphysema	☐	☐
31. Lupus	☐	☐
32. Melanoma	☐	☐
33. Mental or nervous conditions	☐	☐
34. Mental retardation	☐	☐
35. Neurological conditions	☐	☐
36. Phlebitis / Blood clot	☐	☐
37. Polio	☐	☐
38. Sinus conditions	☐	☐
39. Stomach conditions or ulcers	☐	☐
40. Stroke or paralysis	☐	☐
41. Thyroid or pituitary conditions	☐	☐
42. Tuberculosis	☐	☐
43. Tumor, growth, or cyst	☐	☐
44. Ulcerative colitis or Crohn's Disease	☐	☐
45. Varicose Veins	☐	☐
46. Any other condition or treatment in the last 5 years	☐	☐
Other Information		
47. Are you a U.S. Citizen?	☐	☐
48. Are you a resident of the state of Idaho?	☐	☐
years _____ months _____		
49. Do you have a family doctor?	☐	☐
Name _____		

If you answered Yes to any question above, please explain below. Use extra paper if necessary.

Item NO.	Patient's Name	Diagnosis/Condition Type of Treatment	Physician's Name and Address	Date of Illness	Date of Last Visit	Was Recovery Complete?

Have you or any person to be covered taken or used any medication or drug within the **past 12 months**? ☐ Yes ☐ No
If yes, please explain below. Use extra paper if necessary.

Item NO.	Patient's Name	Medication Name	Prescribing Physician and Address	Condition Requiring Medication	Still Taking?

Are you or any of your dependents currently disabled? ..... Yes ☐ No ☐

Name of Disabled Person

Physician's Name and Phone Number

Date of Disability

Physician's Address (street, city, state, and zip code)

Nature of Disability

Have you or any family member, or **any person residing in your household** used tobacco during the past twelve (12) months? ..... Yes ☐ No ☐

Name _____

Type: ☐ cigarettes ☐ chewing tobacco ☐ pipe/cigars

Has surgery, diagnostic testing, medical treatment or follow -up visit been advised (but not yet performed) for any person listed on this application? ..... Yes ☐ No ☐

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

_____

_____

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: _____

_____

_____

Are you or any family members 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 and details: _____

_____

_____

Has any insurance carrier refused, restricted (including waiver or condition), or rated any health coverage for you or any dependents listed on this application? ..... Yes ☐ No ☐

If Yes, please explain (list applicant's name, medical condition and whether refusal, waiver, or restriction) _____

_____

_____

Name of Insurance Carrier _____ Date of refusal, etc. _____

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, deny coverage retroactively and / or 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 pre-existing 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.

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.
- The group's master policy is the document that sets forth all 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 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.**
- NOTE: A pre-existing 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 proceeding 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.

AUTHORIZATION FOR RELEASE OF INFORMATION

To any physician, health care provider, hospital, insurance or reinsurance company, the Medical Information Bureau (MIB) or any other insurance information exchange, or any employer:

I / we authorize, on behalf of any eligible persons named on the application, to give medical information (including information about alcohol, chemical dependency, or mental treatment) you have about us to any interested "Small Employer Carrier" (as defined by Idaho Law), or its representatives. This authorization takes effect on the date shown below. This authorization shall be valid for 12 months from the date following my / our signature(s) below. A photocopy of this authorization is as valid as the original.

Signature of Employee _____ Date _____

Signature of Spouse _____ Date _____

WAIVER OF COVERAGE

To be completed only if coverage is declined or refused by an eligible employee or dependents:

☐ I waive all coverage for myself and dependents

I waive medical coverage for (check one):

☐ Myself (and dependents, if any).
☐ My dependent spouse only
☐ My eligible dependent spouse and children only
☐ My dependent children only
☐ Other (Name) _____

Reason for declining coverage (check one)

☐ Other group coverage through my spouse's employment.
☐ Other individual coverage.
☐ Other (please explain) _____

I have been given the opportunity to apply for group coverage as offered by the employer and, after careful consideration, have decided to waive coverage as indicated above. Should I decide to apply for this coverage in the future, I realize and agree any coverage may be subject to additional waiting periods. **Notice of enrollment rights:** If you are declining enrollment for yourself 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.