St Luke's HEALTH PLAN

Group Employee Application

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

Group Information

TO BE COMPLETED BY GROUP ADMINISTRATOR

Group Number _____ Effective Date _____

Section 1: Employer/Employment Information

1. Name of Employer			2. Phone Number (include area code)	
3. Address		4. City	5. State	6. ZIP Code
7. Occupation	8. Hours Worked per Week	9. Original Date of Hire (mm/dd/yyyy)	10. Full-time Date of Hire (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 (include area code)	8. Email Address	9. Date of Birth (mm/dd/yyyy)	

10. The gender that most closely aligns with your gender identity. ☐ Female ☐ Male	11. Social Security Number (optional)	12. Marital Status ☐ Single ☐ Married ☐ Other_____	13. Types of Enrollment - Please contact your group administrator for plans available to you. ☐ Health ☐ Waive Coverage - see section 3

If you wish to waive coverage for you and/or any dependents at this time, please complete Section 3 – Waiver of Coverage.
If you wish to enroll yourself and/or your dependents, please complete all sections except Section 3.

Section 3: 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 ☐ 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.

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Section 4: Enrollment Information (check all that apply)

1. Are you: ☐ A new hire ☐ Adding or changing dependents ☐ Enrolling during your employer's open enrollment

2. Plan selection (please confirm with your employer if unsure which plans are offered):

☐ Bronze
☐ Bronze HDHP
☐ Silver HDHP
☐ Silver 5500 Rx 750
☐ Silver 5700
☐ Silver 3500
☐ Gold 1800
☐ Gold 1200 Rx 400

3. If you are enrolling outside of your employer's open enrollment or adding dependents, please mark the appropriate reason below and provide the date of the event (mm/dd/yyyy)_____

(documentation may be required) ☐ Marriage ☐ Divorce ☐ Birth ☐ Adoption ☐ New hire

☐ Involuntary loss of employer coverage* ☐ Involuntary loss of individual coverage*

*Provide name of carrier _____

☐ Involuntary loss of Medicaid

☐ Court order (copy of court order required) ☐ Other _____

4. Current employment status:

☐ Actively at work ☐ Retiree ☐ COBRA participant ☐ Disability ☐ Other

Section 5: Dependent Information

Dependent's Name (first, initial, last)	Relationship (spouse, child, stepchild, etc.)	Does Dependent live at the same address as you?	Social Security Number (optional)	Date of Birth (mm/dd/yyyy)	Gender	Type of Enrollment
Dependent 1		☐ Yes ☐ No			☐ Male ☐ Female	☐ Health ☐ Dental
Dependent 2		☐ Yes ☐ No			☐ Male ☐ Female	☐ Health ☐ Dental
Dependent 3		☐ Yes ☐ No			☐ Male ☐ Female	☐ Health ☐ Dental
Dependent 4		☐ Yes ☐ No			☐ Male ☐ Female	☐ Health ☐ Dental
Dependent 5		☐ Yes ☐ No			☐ Male ☐ Female	☐ Health ☐ Dental
Dependent 6		☐ Yes ☐ No			☐ Male ☐ Female	☐ Health ☐ Dental

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.

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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.

1. Other Insurance Carrier Information: Insurance Carrier Name, Policy Number, Phone Number			
2. Policyholder Name		3. Names of Covered Members	
4. Types of Coverage (check all that apply) ☐ Group ☐ Medical ☐ Individual ☐ Dental ☐ Medicare ☐ Vision	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 Workers' Compensation payments or are now eligible to receive such payments? ☐ No ☐ Yes

If yes, give person's name, type of coverage, and reason for entitlement: _____

Section 8: Affirmation

I affirm the answers in this "Group Employee 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 on the part of the employer is cause for retroactive termination of coverage by the insurance carrier and/or other action available by 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: Electronic Communication Delivery Agreement

To provide you with a convenient and mobile avenue to access all of your health insurance documents and to reduce the use of paper, St. Luke's Health Plan sends communications to members through a secured member account and provides notification by email to the email address you supply in your application when we post a new communication to your secure account.

Below is your agreement to receive electronic copies unless you indicate a preference to receive paper copies.

Unless I reject electronic distribution by checking the checkbox below, I consent by my signature on behalf of myself and any covered dependents to the electronic distribution of communications related to the coverage I have applied for, and agree that I consent to:

- Electronically receive any materials that are currently available electronically as well as those that become available in the future; printed and mailed copies will be sent to your mailing address prior to the availability of electronic copies.
- Electronically receive the following materials: explanation of benefits statements (EOBs); enrollment, billing, and renewal notices; information requests; claims receipts and decisions, including adverse benefit determinations; legally required information and notifications, including but not limited to notices about any federal or state rules and regulations; information regarding complaints, appeals, or grievances; coverage summaries; benefit and policy changes; discontinuation or termination notices; and health and wellness information I have requested or has been requested on my behalf by my employer.
- To receive a printed copy of any electronic notice, you can print a copy from your secure member account or call Customer Service at the number listed on the back of your member ID card.
- To easily change your communication preferences, log into your member account, select My Account from the top menu or visit your member preference center found at the footer of any email you receive.

☐ No, I do not want electronic distribution of communications. Unless my consent is not required for an electronic distribution, I elect to receive communications related to my coverage in a paper format.

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Section 10: 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 by the employer 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 11: Acknowledgment

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 acknowledgment 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) _____

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