GROUP INFORMATION

TO BE COMPLETED BY GROUP ADMINISTRATOR
Group Number_____ Effective Date _____ Subgroup_____ Class_____

IDAHO AGC HEALTH PLAN LARGE GROUP APPLICATION

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
5. Preferred **Daytime** Phone Number ( )	6. Email Address		7. Marital Status ❑ Single ❑ Married ❑ Other
Gender ❑ Male ❑ Female	**8.** Social Security Number **(required)**		9. Date of Birth *(mm/dd/yyyy)*
10. Height	11. Weight		

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 **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.

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SECTION 4 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, please mark the appropriate reason below and provide the date of the event (mm/dd/yyyy) _____
   (documentation may be required) ❑ Marriage ❑ Divorce ❑ Birth ❑ Adoption
   - ❑ 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 _____

3. Type of enrollment:

	HEALTH	DENTAL	VISION
Self Only	❑	❑	❑
Self and spouse	❑	❑	❑
Self, spouse & dependents	❑	❑	❑
Self & one dependent	❑	❑	❑
Self & two or more dependents	❑	❑	❑

4. Current employment status:

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

SECTION 5

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

Dependent's Name (first, initial, last)	Social Security Number	Relationship (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yyyy)	Height	Weight	Gender
Dependent 1						❑ Male ❑ Female
Dependent 2						❑ Male ❑ Female
Dependent 3						❑ Male ❑ Female
Dependent 4						❑ Male ❑ Female
Dependent 5						❑ Male ❑ Female
Dependent 6						❑ Male ❑ Female

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.)

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 ❑ Medical
   ❑ Individual ❑ Dental
   ❑ Medicare ❑ Vision

7. Coverage Start Date *mm/dd/yyyy*

7. Is this coverage terminating?
   ❑ Yes (complete #7)
   ❑ No

7. Coverage End Date *mm/dd/yyyy*

8. Are you or any dependent listed on this application covered on Medicare or have received Social Security Disability or Worker'sCompensation payments or are now eligible to receive such payments?
   ❑ **No**
   ❑ **Yes** If yes, give person's name, type of Coverage, and reason for entitlement: _____ _____

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SECTION 7

HEALTH STATEMENT

(Complete this health statement if you apply for coverage for yourself or a family member after the original eligibility period.)

1. Have you or any family member listed on this application ever been advised to have any surgical operation(s) that you or any family member have not yet had?
   ❑ **YES** ❑ **NO**

2. Do you or any family member listed on this application suffer from any chronic or recurring ailments, illnesses or other departures from good health, regardless of whether a physician or other health care professional has been consulted?
   ❑ **YES** ❑ **NO**

3. During the past 12 months, have you or any family member listed on this application received a prescription for medication from a physician or taken any prescribed medication?
   ❑ **YES** ❑ **NO**

4. Are you or any family member listed on this application now pregnant?
   ❑**YES** ❑ **NO** If pregnant, what is the anticipated delivery date?

5. Have you or any family member listed on this application ever been refused or issued restricted health insurance coverage?
   ❑ **YES** ❑ **NO**

6. Have you or any family member listed on this application been hospitalized during the last 5 years?
   ❑ **YES** ❑ **NO**

7. Within the past two years, have you or any member of your family been treated for back/joint disorder?
   ❑ **YES** ❑ **NO**

8. Have you or any family member listed on this application ever had, been told he or she had, been counseled or treated for any of the following: alcohol/drug use or abuse, cancer, heart problem/disorder, diabetes, digestive disorder, immune disorder, renal/kidney disease, strokes, mental or nervous disorders or respiratory disorders?
   ❑ **YES** ❑ **NO**

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, Dosage, Strength and Duration	Name of Physician

9. 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:

_____ _____

_____ _____

10. 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 _____

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SECTION 8 AFFIRMATION

I affirm the answers in this "Idaho AGC Health Plan Large Group Application" are complete and correct. I am providing these answers as part of the application procedure required by the Idaho AGC Health Plan to enroll in its coverage. I understand that the Idaho AGC Health Plan 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 Idaho AGC Health Plan may take any action available by law, including but not limited to, retroactive adjustment of contributions 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 Idaho AGC Health Plan and/or other action available by law. I will promptly inform the Idaho AGC Health Plan 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 Idaho AGC Health Plan 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 Idaho AGC Health Plan, or of my employer, can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The Idaho AGC Health Plan 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 Idaho AGC Health Plan'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 Idaho AGC Health Plan 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 Idaho AGC Health Plan.
- 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 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)*

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

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