



Enrollment Application Small Group

Reason for Application

- New Hire
- Open Enrollment
- Address Change
- Add Dependent(s)
- Marriage
- Divorce
- Coverage Termination
- Cobra

Company Name: _____

Group Number: _____

Average Hours Worked per Week: _____

Date of Hire: _____

Effective Date: (mm/dd/yyyy) _____

Is Employee Actively at Work? Yes No

Date Event Occurred: ____/____/____

Employee Information

Employee Name (first, initial, last):		<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Other _____	
Address:		Occupation:	
City:	State:	Zip:	
Daytime Phone:	Evening Phone:	Email Address:	

List self and family members to be covered. If you need more room, please use an additional application.

Self and Family Member Names (first, initial, last)	Relationship to	Weight	Height	Gender	Date of Birth	Dependent Claimed on US Income Taxes? Yes/No	Social Security Number
Employee	Self						
Spouse							
Child 1							
Child 2							
Child 3							
Child 4							

Credit for Prior Coverage. Please complete for credit to waiting periods and for proper coordination of benefits.

Self and Family Member Names (first, initial, last)	Name of Insurance Carrier	Policy Number	Individual or Group?	Policy Date From	Policy Date To	Will This Policy Continue? Yes/No
Employee						
Spouse						
Child 1						
Child 2						
Child 3						
Child 4						

Notice of Preexisting:

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain 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 ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 60 days after birth, adoption, or placement for adoption.

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.

To reduce the 12-month exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the preexisting condition exclusion and creditable coverage should be directed to Primary Health Plan, Enrollment Department, P.O. Box 5679, Boise ID 83705 or call 333-1596 or out of the Boise area at (800) 688-5008, ext: 596.

PO Box 5679 • Boise, ID 83705 • (208) 333-1596 • (800) 688-5008, ext. 596

www.primaryhealth.com

Disability Information. If you or any of your dependents are currently disabled, please fill in the following information.

Name of Disabled Person	Date of Disability	Cause of Disability	Physician's Name	Physician's Address	Physician's Phone

Health Statement. Please answer each question completely and accurately.

The following health questions apply to each person listed on this application. The questions pertain to both past and present symptoms, conditions, diseases, illnesses, accidental injuries, and deformities ("health conditions"). Answer each question accurately and completely. Coverage under the group contract will not begin until Primary Health Plan approves the application. 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. Primary Health Plan shall not be bound by an attempted waiver of complete answers to the questions set forth below.

If you learn at any time before the effective date of coverage by Primary Health Plan that any answer on this application is incomplete or has changed, you must immediately advise Primary Health Plan in writing.

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| <p>1. Are you, your spouse, any eligible dependent child, or mate, whether or not listed on this application, now pregnant?.....<input type="checkbox"/> Yes <input type="checkbox"/> No
Due Date.....___/___/___
Complications anticipated?...<input type="checkbox"/> Yes <input type="checkbox"/> No
Prior or multiple births Anticipated?.....<input type="checkbox"/> Yes <input type="checkbox"/> No
Prior of anticipated C-section?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Positive test for HIV (Human Immunodeficiency Virus) infection?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Alcoholism, drinking problem, drug abuse, or charged with DUI/DWI? ...<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Allergies or Hay Fever?<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Anemia or blood disorder?....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Arthritis or rheumatism?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Asthma or chronic bronchitis?<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Attempted suicide?<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Back or joint condition?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Bladder or kidney condition? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Bodily deformity or congenital disease / defect?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>13. Bone infection?<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Breast condition or fibrocystic breast disease?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Cancer?<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Colon / Bowel / Rectal condition?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>17. Depression?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Diabetes?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>19. Disorders of the female reproductive organs /infertility?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>20. Disorders of the male reproductive organs including the prostate / infertility?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>21. Dizziness or headaches?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Epilepsy or seizure condition?<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>23. Eye, ear, nose or throat condition?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>24. Gallstone or gall bladder condition?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>25. Heart or cardiovascular condition?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>26. Hernia or rupture?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>27. High blood pressure?.....<input type="checkbox"/> Yes <input type="checkbox"/> No
Last reading?
Date of reading?___/___/___</p> <p>28. High cholesterol?.....<input type="checkbox"/> Yes <input type="checkbox"/> No
Last reading
Date of reading?___/___/___</p> | <p>29. Liver conditions, cirrhosis or hepatitis?<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>30. Lung conditions or emphysema?<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>31. Lupus?<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>32. Melanoma?<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>33. Mental or nervous conditions?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>34. Mental retardation?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>35. Neurological conditions?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>36. Phlebitis / Blood clots?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>37. Polio?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>38. Sinus conditions?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>39. Skin conditions?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>40. Stomach conditions or ulcers?<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>41. Stroke or paralysis?<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>42. Thyroid or pituitary conditions?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>43. Tuberculosis?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>44. Tumor, growth, or cyst?<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>45. Ulcerative colitis or Crohn's Disease?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>46. Varicose veins?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>47. Any other condition or treatment in the last 5 years?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>48. Are you a U.S. Citizen?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
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If you checked YES to any question above, please provide details below (please use extra paper if necessary):

Item #	Person Affected	Date of Onset	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

During the past 12 months have you or any family member listed on this application received a prescription for medication from a medical provider or taken any medication or drug? Yes No

If you checked YES, please provide details below (please use extra paper if necessary):

Item #	Person Taking Medication	Name of Medication	Name of Prescribing Physician	Condition Requiring Medication	Still Taking Medication?

Health Questions. Please answer each question completely and accurately.

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

Name(s): _____ Type(s): Cigarettes Chewing Tobacco Pipe/Cigars

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

Name(s): _____ Details: _____

Has any person incurred medical expenses or claims exceeding \$10,000 in the past twenty-four (24) months? Yes No

Name(s): _____ 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

Name(s): _____ Details: _____

Do you or any family members listed on this application suffer from any chronic or recurring ailments or illnesses or other departures from good health, regardless of whether a physician or other health care professional has been consulted? Yes No

Name(s): _____ Details: _____

Waiver of Coverage. If you do NOT want to enroll yourself or your dependents in Primary Health Plan, please fill out the following information.

<p>I hereby waive coverage:</p> <p><input type="checkbox"/> Self</p> <p><input type="checkbox"/> Spouse</p> <p><input type="checkbox"/> Child 1 Name: _____</p> <p><input type="checkbox"/> Child 2 Name: _____</p> <p><input type="checkbox"/> Child 3 Name: _____</p> <p><input type="checkbox"/> Child 4 Name: _____</p>	<p>Reason for Waiver</p> <p><input type="checkbox"/> Other group coverage through my spouse's employer.</p> <p><input type="checkbox"/> Other individual coverage.</p> <p><input type="checkbox"/> Other (please explain)</p> <p>_____</p>	<p>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. Should I decide to apply for this coverage in the future, I realize and agree any coverage may be subject to additional waiting periods.</p>
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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 if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). For this special enrollment to apply, an employee or dependent of an employee must be eligible for coverage but not currently enrolled in the plan, and must have had coverage under another group health plan (or through health insurance) at the time coverage under the plan was previously offered and waived. 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 you request enrollment within 60 days after the qualifying event. To request special enrollment or obtain more information, contact Primary Health Plan, Enrollment Department, P.O. Box 5679, Boise ID 83705 or call 333-1596 or out of the Boise area at (800) 688-5008, ext: 596.

Affirmation. Please read carefully before signing.

By signing this enrollment form, I affirm that all my answers are complete and accurate, and that I understand and agree to the following conditions:

- No independent producer, agency or employee of Primary 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.
- Primary Health Plan may, at its discretion, request supplemental information from me and/or any family member listed on this application or any physician, health care provider, hospital, insurance or reinsurance company, the Medical Information Bureau (MIB) or any other insurance information exchange. On behalf of myself and all enrolled family members, I understand if Primary Health Plan discovers any intentional misrepresentation, omission or concealment of fact in obtaining coverage that was or would have been material to Primary Health Plan's acceptance of risk, Primary Health Plan may take action against me and/or my employer, including but not limited to increasing premiums and/or may take any other action available by law.
- I will promptly inform Primary Health Plan in writing if changes occur before my coverage takes effect that makes any answer on this application incomplete or inaccurate.
- I understand and agree no coverage shall be in force until approved by Primary Health Plan. If approved, coverage will be in force as of the effective date determined by Primary Health Plan.
- My employer's *Master Policy and Contract* is the document that sets forth all terms of my coverage. No independent producer, agency or employee of Primary Health Plan, or of my employer can change the terms of the *Master Policy and Contract*, or any of its amendments.

I authorize any physician, health care provider, hospital, insurance or reinsurance company, the Medical Information Bureau (MIB) or any other insurance information exchange, or any employer, on behalf of myself and any family member listed, to give medical information (including information about alcohol, chemical dependency, or mental treatment) about us to Primary Health Plan as defined by Idaho Law or its representatives. This authorization takes effect on the date shown below. The authorization shall be valid for 30 months from the date following my signature below. A photocopy of this authorization is as valid as the original.

Signature of Applicant _____ Date _____

Signature of Spouse _____ Date _____

SIGNATURE OF SPOUSE IS REQUIRED FOR COVERAGE