

PA 2-20 SMALL GROUP EMPLOYEE APPLICATION

Instructions: Do Not Type. You, the employee, must complete the application in your own handwriting. You are solely responsible for its accuracy and completeness. All questions must be answered in full or the application may be returned to you resulting in a delay. Print clearly using ink. When you have completed and signed the Health Questionnaire, please detach at the perforation, and seal in the attached envelope. Prior to sealing, please be sure your name is on both the Application and the Health Questionnaire. Typed applications will not be accepted.

For members enrolled in the HealthAmerica HMO: HealthAmerica products are made available through HealthAmerica Pennsylvania, Inc. For members enrolled in the HealthAssurance PPO and CCPPPO (POS): HealthAssurance products are made available through HealthAssurance Pennsylvania, Inc. For out-of-area members enrolled in HealthAssurance PPO: HealthAssurance products are made available through Coventry Health & Life Insurance Company. If you have any questions about which products you are enrolling in, call our Member Services staff at 1-800-788-8445 in Central/Eastern PA and 1-800-735-4404 in Western PA or contact your employer.

Employee Information (Must be completed by employee) <input type="checkbox"/> Employee Enrollment		<input type="checkbox"/> COBRA Qualified Beneficiary				
Last Name		First Name		MI	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	
Home Address (P.O. Box not acceptable unless rural P.O. Box)			Apt #	Home Phone #		Work Phone #
City		State	Zip	Employee/Spouse Maiden Name		
Employer Name		Occupation/Job Title		Hire Date	Hours Worked	

Employee/Dependent Information (List yourself and only those eligible dependents who are enrolling.)

If dependent child is not the legally adopted or birth child of you or your spouse, please explain why the child is a dependent.

Please don't forget to provide the Social Security Number of dependents and last name if it differs from the subscriber's last name.

Sex (M/F)	Last Name	First Name	MI	Soc. Sec. No.	Height	Weight	Student/Disabled (Y/N)	Birthdate MM/DD/YY	PCP Site Code
	Employee								
	Spouse								

Coverage Declaration (To be completed if coverage is declined or refused by an eligible employee and/or their dependent(s).)

- A. Coverage declined for: Myself Spouse Dependent(s) Spouse and Dependent(s)
- B. Reason for declining coverage (check one):
- Covered by spouse's group coverage — Carrier Name and I.D. #: _____ Covered by TRICARE for Life
- Spouse covered by employer's group medical coverage — Carrier Name and I.D. #: _____ Medicare
- Enrolled in any other insurance carrier plan — Carrier Name and I.D. #: _____ Other: _____

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. **I UNDERSTAND THAT BY DECLINING THIS GROUP MEDICAL COVERAGE, MY DEPENDENTS AND I MAY BE REQUIRED TO WAIT UNTIL THE NEXT OPEN ENROLLMENT PERIOD, IF ANY, TO ENROLL IN THIS GROUP MEDICAL COVERAGE.**

Sign only if declining coverage

Signature only if declining coverage for employee and/or dependent(s) _____ Date (MM/DD/YYYY) _____

Authorization I understand that my signature and my spouse's signature (if applying for coverage) are mandatory on this release. This application will not be reviewed until these signatures are present.

I AGREE: All information on this form and the attached Health Questionnaire is correct and true. I understand that it is the basis on which premiums may be determined under the plan. I further authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan. I certify that I am working at the employer's place of business in permanent employment at least 25 hours a week. Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy being rescinded. **I ACKNOWLEDGE THAT** I am applying for Health Maintenance Organization (HMO), Preferred Provider Organization (PPO) or Coordinated Care Preferred Provider Organization (POS) coverage. I understand that in the case of HealthAssurance PPO and POS, I am responsible for a greater portion of the cost of my covered medical costs when I use a non-participating provider. I understand that under the PPO and POS if I or one of my dependents receive medically necessary covered services from a non-participating provider, HealthAssurance will cover only the lower level benefits set forth in the applicable Certificate of Insurance and I will be responsible for payment of any amount not covered by HealthAssurance. I understand that in the case of HealthAmerica HMO, all covered medical services must be performed or coordinated by my HealthAmerica Primary Care Physician, obtained from a participating provider, and that some services must be authorized by HealthAmerica.

CONSENT TO USE, DISCLOSE, OR ACQUIRE PERSONAL INFORMATION TO BE INCLUDED ON ENROLLMENT FORM: By signing this form, I agree on behalf of myself and those family members enrolled in the Health Plan (Dependents), for whom I have the authority to enroll and to consent on their behalf (collectively my Dependents and I shall be referred to as my Enrolled Family), that Health Plan may use or disclose to third parties the information contained on this enrollment form and individually identifiable health information relating to my Enrolled Family for purposes of administering my health insurance benefit, including for treatment, payment or health care operations, as those terms are explained in detail in Health Plan's Notice of Privacy Practices and to the extent permitted by law. My Enrolled Family's consent includes agreement for the use or disclosure of health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness, including substance abuse, autoimmune deficiency syndrome (AIDS), AIDS related complex (ARC), human immunodeficiency virus (HIV) or genetic conditions.

By signing this form, I also agree on behalf of myself and my Dependents, that, to the extent permitted by law, health care providers, insurers, claims administrators, employers and others may disclose my Enrolled Family's personal information including individually identifiable health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness, including substance abuse, AIDS, ARC, HIV or genetic conditions to Health Plan for Health Plan's administration of health insurance benefits, including for treatment, payment or health care operations purposes and other purposes permitted by law.

Health Questionnaire for Groups with 2-20 Employees

Employee Name _____

Health history of you and your family (including information about family members you wish to cover) — Has any person listed on this application ever had, consulted for, sought treatment, had treatment recommended, received treatment, been surgically treated or been hospitalized for any of the following conditions: *(Please answer Yes or No. Incomplete applications will be returned to you for completion which may delay the effective date of your coverage.)*

	Yes	No		Yes	No
1. Heart attack, heart murmur, stroke, chest pain, high blood pressure*, anemia, varicose veins, or any other disorder of the heart, blood, blood vessels, hyperlipemia or arteriosclerosis, high cholesterol* or diabetes*? _____	<input type="checkbox"/>	<input type="checkbox"/>	8. Any serious bodily injury, fracture, concussion, burn and/or congenital problems? _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Ulcer, colitis, gall stone, hernia or any other disorder of the stomach, intestines, rectum, gall bladder, or liver? _____	<input type="checkbox"/>	<input type="checkbox"/>	9. Any immune deficiency disorder, HIV, AIDS, or AIDS-related complex? _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Cancer, cyst, or tumor? _____	<input type="checkbox"/>	<input type="checkbox"/>	10. Within the last five years, had an X-ray, electrocardiogram, cardiac catheterization, or any laboratory test or study? _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Disorder of the kidneys, blood or albumin, thyroid glands, venereal disease or any related eye disorders, urinary systems, male or female organs, or menstrual dysfunction? _____	<input type="checkbox"/>	<input type="checkbox"/>	11. Within the last 12 months, taken medicine as prescribed by a physician or other health practitioner? _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Tuberculosis, asthma, hay fever, adenoidectomy, pleurisy or any other kind of disorder of the lungs or respiratory system? _____	<input type="checkbox"/>	<input type="checkbox"/>	12. Been treated for alcoholism or other drug or substance abuse or been advised to seek treatment for the same? _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Epilepsy, fainting spells, mental or nervous condition, paralysis or any other disorder of the brain or nervous system? If epileptic, date of last seizure: _____	<input type="checkbox"/>	<input type="checkbox"/>	13. Is any female to be covered currently pregnant? If yes, Due Date (Month)? _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Arthritis, rheumatic fever, back trouble, or any other disorder of the joints, muscles, or bones? _____	<input type="checkbox"/>	<input type="checkbox"/>	13a. Is any male listed on this application expecting a child with anyone, even if the mother is not listed on this application? _____	<input type="checkbox"/>	<input type="checkbox"/>
			14. Any history of pregnancy complication? _____	<input type="checkbox"/>	<input type="checkbox"/>

***Please provide the last three readings in the spaces below.**

If you answered "Yes" to any of the questions above, you must complete the following. Please explain and provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked in all the preceding boxes. Please give details below on the last doctor visit and/or physical examination for ALL family members listed regardless of date or reason. *(Insert additional sheets if necessary.)*

Question #	Name of family member (As identified on physician's record)	Name of Hospital, Clinic, or person providing care	Phone #
Date of onset/treatment (Month/Year)	Date Ended <input type="checkbox"/> Still under treatment	Address	Suite #
Name of Condition(s)/Illnesses Treated		City, State, Zip Code	
Treatment Rendered		Medication (if taken)/Date Prescribed/Dosage	

Blood Pressure: #1 #2 #3			Blood Sugar: #1 #2 #3			Cholesterol: #1 #2 #3		
Question #	Name of family member (As identified on physician's record)	Name of Hospital, Clinic, or person providing care	Phone #					
Date of onset/treatment (Month/Year)	Date Ended <input type="checkbox"/> Still under treatment	Address	Suite #					
Name of Condition(s)/Illnesses Treated		City, State, Zip Code						
Treatment Rendered		Medication (if taken)/Date Prescribed/Dosage						

Blood Pressure: #1 #2 #3			Blood Sugar: #1 #2 #3			Cholesterol: #1 #2 #3		
Question #	Name of family member (As identified on physician's record)	Name of Hospital, Clinic, or person providing care	Phone #					
Date of onset/treatment (Month/Year)	Date Ended <input type="checkbox"/> Still under treatment	Address	Suite #					
Name of Condition(s)/Illnesses Treated		City, State, Zip Code						
Treatment Rendered		Medication (if taken)/Date Prescribed/Dosage						

Blood Pressure: #1 #2 #3			Blood Sugar: #1 #2 #3			Cholesterol: #1 #2 #3		
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Other Medical Coverage for ALL Enrolling Employees and Dependents *(All questions must be answered.)*

A. Do any persons on this application intend to continue other group coverage if this application is accepted? Yes No
 If yes, Name of person: _____ Insurance Company: _____

B. Does any person applying for coverage have health insurance coverage? Yes No
 If yes, Employee/family member(s) name: _____ Type of continuous coverage: Group Individual Other
 Insurance Company: _____ Date coverage began: _____ Date ended: _____

C. Does any person applying for coverage currently have Dental Insurance Coverage? Yes No Type: _____
 Insurance Company: _____ Date coverage began: _____ Date ended: _____

D. Is any person applying for coverage eligible for Medicare? Yes No

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.