

APPLICATION INSTRUCTIONS:

- 1 This application must be completed by the applicant for himself/herself and all eligible dependents.
 - Group Plan Administrator may complete an employee application on behalf of the employee per the following criteria:
 - i. The employee is court ordered to provide coverage for a dependent, or
 - ii. The Group Plan Administrator wishes to add or terminate employees and/or dependents through the Cox HealthPlans online Administrator access.
 - The Group Plan Administrator may NOT complete an enrollment form on behalf of an employee when medical information is required for underwriting purposes.
 - 2 Please print using a ball point pen and complete all questions.
 - 3 Be sure to sign and date where indicated and on any additional pages you may include.
- Incomplete or forms completed in pencil will be returned and may delay coverage.**

SECTION A: APPLICANT INFORMATION

1	LEGAL NAME (Last, First, MI)	SOCIAL SECURITY #:	BIRTH DATE:	GENDER: M F	HEIGHT:	WEIGHT:
	CURRENT ADDRESS:	COUNTY:			USE TOBACCO: Y N	
	CITY:	STATE:	ZIP:	E-MAIL ADDRESS:		
	HOME PHONE:	WORK PHONE:	CELL PHONE:	PRIMARY LANGUAGE:		
2	MARITAL STATUS (Select One): SINGLE/DIVORCED/WIDOWED MARRIED	GROUP/COMPANY/EMPLOYER NAME:	OCCUPATION:	DATE OF HIRE:		

SECTION B: REASON FOR APPLICATION *Note: If waiving coverage, please check and skip to Section I*

1	<input type="checkbox"/> New Subscriber <input type="checkbox"/> Add Dependents (List below) <input type="checkbox"/> Terminate Dependents (List below) <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change	<input type="checkbox"/> Retiree <input type="checkbox"/> COBRA / State Continuation: Continuation Start date: _____ <input type="checkbox"/> Special Enrollment: Qualifying Event Type: _____ Qualifying Event Date: _____
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SECTION C: PRODUCT & COVERAGE SELECTION

1	PRODUCT: <input type="checkbox"/> HMO - Cox Health Systems HMO, Inc. If dual option, indicate plan: _____
2	COVERAGE: <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> EMPLOYEE & SPOUSE <input type="checkbox"/> EMPLOYEE & CHILD(REN) <input type="checkbox"/> EMPLOYEE & FAMILY

SECTION D: DEPENDENT INFORMATION (If additional space is needed, back of page 1 may be used.)

ENROLL/ CHANGE/TERM	LEGAL NAME (Last, First, MI)	RELATIONSHIP	SOCIAL SECURITY #	GENDER	BIRTH DATE (mm/dd/yy)	HEIGHT	WEIGHT	USE TOBACCO
				M F				Y N
				M F				Y N
				M F				Y N
				M F				Y N
				M F				Y N
				M F				Y N

SECTION E: HEALTH INFORMATION (*This information is only required for underwriting purposes.*)

1	Have you or any of your dependents had medical expenses in excess of \$5,000, or received inpatient or outpatient hospital care, within the last 12 months? (<i>If yes, please complete Section F</i>)	<input type="checkbox"/> Yes*	<input type="checkbox"/> No																
2	Are you or any of your dependents currently disabled? (<i>If yes, please complete Section F</i>)	<input type="checkbox"/> Yes*	<input type="checkbox"/> No																
3	Are there any conditions diagnosed or treated in the last 5 years?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No																
4	In the last 5 years, have you had any abnormal test or physical results, tests/treatment/surgery advised, pending test results, referral to a specialist or condition?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No																
5	Do you or any of your dependents take any medicine(s), drugs or pills or require shots?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No																
6	Within the last 10 years, have you or any dependent listed on this application ever been diagnosed with or treated for any conditions of the body systems listed below: <p style="text-align:center;"><u> </u> None of the conditions listed below</p> <table style="width:100%; border:none;"> <tr> <td style="vertical-align:top; width:25%;"> Brain/Nervous <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Paralysis <input type="checkbox"/> Parkinson's <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Other: _____ </td> <td style="vertical-align:top; width:25%;"> Digestive <input type="checkbox"/> Crohn's <input type="checkbox"/> Gallbladder <input type="checkbox"/> Gastric/Peptic Ulcer <input type="checkbox"/> Hernia Type: _____ <input type="checkbox"/> Liver Disorder <input type="checkbox"/> Cirrhosis <input 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IF YES INDICATED TO ANY OF THE CONDITIONS LISTED ABOVE - PLEASE COMPLETE SECTION F																			

SECTION F: HEALTH INFORMATION CONTINUED (*Please provide full details for any conditions checked or questions answered "Yes" in Section E above. Use additional paper if necessary. Please sign and date all pages.*)

LEGAL NAME (Last, First, MI)	DIAGNOSIS/CONDITION	DATE LAST TREATED OR INDICATE 'ONGOING'	TREATMENT RECEIVED/EXPECTED TO RECEIVE

SECTION G: MEDICATION INFORMATION: (*Please provide full details for any medications currently taken*)

LEGAL NAME (Last, First, MI)	DIAGNOSIS/CONDITION	NAME OF MEDICATION	START DATE	FREQUENCY	DOSAGE

SECTION H: TERMS, CONDITIONS, AUTHORIZATIONS, AND OTHER PROVISIONS

1 I declare that I am an employee regularly scheduled to work full time (as defined by employer), year round, for full pay, at my employer's normal place of work and in the employer's normal business and request to be insured.

2 **Authorization:** I authorize any physician, hospital, clinic, other medical or medically related facility, or insurance company to release to Cox Health Systems HMO, Inc ("CHMO"), its legal representatives or its reinsurers, any information, record or knowledge of the health of any persons proposed for insurance for determination of claims. This consent includes information about drug and alcohol use. I authorize any consumer reporting agency that has any record, public record or knowledge of any persons proposed for insurance to give to CHMO, its legal representatives or reinsurers, any such record or knowledge for purposes of underwriting insurance. A photographic copy of this consent shall be as valid as the original.

I understand that I may revoke this authorization for information by supplying the revocation in writing to the Home Office of CHMO. I understand that the revocation will not be in effect until it is received at the Home Office. Unless revoked, I agree that, when signed in connection with an application for, reinstatement of, or request for change in benefits, this form shall be valid for two years after the date shown below.

3 **Representation:** I hereby declare I have read, or had read to me, the questions and responses on this application. I represent that all information, statements, and answers made on this form, and any attachments, about myself or any dependents' state of health, are complete and true to the best of my knowledge. I understand that they shall be a part of this request for coverage under the group's policy. I realize any false statements, omissions and/or material misrepresentations regarding any information requested on this form, could cause an otherwise valid claim to be denied and/or cause the insurance coverage, if issued, to be cancelled as never effective. For any applicant listed on this form, after coverage has been in effect for two (2) years, no statement will void the coverage or reduce the benefits, unless the statement was material to the risk assumed, fraudulent, and contained on this form.

NOTICE: Any person who, knowingly or with intent to defraud any insurance company or other person, files an application of 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.

4 **Important Information:** I understand no coverage under this insurance exists unless and until approved by Cox Health Systems HMO, Inc. at its home office in Springfield, Missouri. If at any time prior to such approval, anyone applying for coverage under this application consults a doctor, is hospitalized, or has any change in health, I agree to inform CHMO and understand that I am responsible for all charges incurred.

5 I understand that no producer, agent, or broker may change or waive any rates, benefits, or provisions of the policy, if issued, without the written approval of an officer of CHMO.

SIGNATURE REQUIRED

X _____

Signature of Enrolling Employee* Date Signed

* A Group Plan Administrator may sign on behalf of the employee under certain circumstances. Please refer to the "Application Instructions" section for more details.

SECTION I: WAIVER OF COVERAGE (If you are waiving coverage for any reason, including other coverage, you must complete this section, Section A, read Section H, then sign and date this form.)

1 I am declining coverage for:

<input type="checkbox"/> Myself	Declining coverage due to existence of other coverage:	
<input type="checkbox"/> Spouse	<input type="checkbox"/> COBRA or State Continuation *	<input type="checkbox"/> Medicaid
<input type="checkbox"/> Dependent Child(ren)	<input type="checkbox"/> Coverage under Spouse's group plan *	<input type="checkbox"/> Medicare or Champus (Tri-Care)
<input type="checkbox"/> Myself and all dependents	<input type="checkbox"/> Individual Health Plan *	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> I (we) have no other coverage at this time	

2 * If you are waiving due to other coverage, you must provide a copy of your insurance card or list your information below:
Insurance Company Name: _____ Policy #: _____

Waiving Coverage: If you are declining enrollment for you or your dependents, you must wait until the next open enrollment period for your group to enroll unless you meet the special enrollment rules described below:

Rule #1: Eligibility for coverage under other employer sponsored group health plan ends; except for failure to pay premiums or termination for cause.

Rule #2: Loss of coverage as a result of exhaustion of COBRA benefits, eligibility for coverage including legal separation, divorce, death, termination of employment, reduction of hours, or your employer contributions for coverage were terminated.

Rule #3: Newly acquired dependent as a result of marriage, birth, adoption, or placement for adoption, and a court or administrative order stating the employee shall provide insurance for dependent child(ren).

The eligible covered employee or dependent will have a special enrollment period of thirty-one (31) days within which to submit the required forms to enroll, that begins on the date of the qualifying event.

X _____

Signature of Employee Waiving Coverage (sign only if waiving coverage) Date Signed