Cox HealthPlans
CoxHealth

EMPLOYEE APPLICATION FOR GROUP HEALTH INSURANCE

Cox Health Systems Insurance Company

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.
- ☐ New Subscriber
- ☐ Add Dependents (List below)
- ☐ Terminate Dependents (List below)
- ☐ Address Change
- ☐ Name Change
- ☐ Retiree
- ☐ COBRA / State Continuation: Continuation Start date: ______________
- ☐ Special Enrollment: Qualifying Event Type: ______________
  Qualifying Event Date: ______________

SECTION C: PRODUCT & COVERAGE SELECTION

1. PRODUCT:
   ☐ PPO - Cox Health Systems Insurance
   If dual option, indicate plan: ______________________
2. COVERAGE:
   ☐ EMPLOYEE ☐ EMPLOYEE & SPOUSE ☐ EMPLOYEE & CHILD(REN) ☐ 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
				M F				Y N

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

#	Question	Yes*	No
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? *(If yes, please complete Section F)*	☐ Yes*	☐ No
2	Are you or any of your dependents currently disabled? *(If yes, please complete Section F)*	☐ Yes*	☐ No
3	Are there any conditions diagnosed or treated in the last 5 years?	☐ Yes*	☐ No
4	In the last 5 years, have you had any abnormal test or physicial results, tests/treatment/surgery advised, pending test results, referral to a specialist or condition?	☐ Yes*	☐ No
5	Do you or any of your dependents take any medicine(s), drugs or pills or require shots?	☐ Yes*	☐ 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:

___ **None of the conditions listed below**

Brain/Nervous
- ___ Alzheimer's
- ___ Cerebral Palsy
- ___ Headaches
- ___ Migraines
- ___ Multiple Sclerosis
- ___ Paralysis
- ___ Parkinson's
- ___ Seizures/Epilepsy
- ___ Other: ___________

Bones/Muscular
- ___ Arthritis
- ___ Rheumatoid Arthritis
- ___ Osteoporosis
- ___ Lupus
- ___ Back/Neck Pain or Disorders
- ___ Bulging/Herniated Disk
- ___ Joint Pain
- ___ Muscular Dystrophy
- ___ Other: ___________

Cancer/Tumor
- ___ Brain
- ___ Breast
- ___ Colon
- ___ Leukemia
- ___ Liver
- ___ Lung
- ___ Lymphoma
- ___ Melanoma
- ___ Prostate
- ___ Skin
- ___ Uterine/Cervical/Ovarian
- ___ Other: _______

Digestive
- ___ Crohn's
- ___ Gallbladder
- ___ Gastric/Peptic Ulcer
- ___ Hernia
  Type: ___________
- ___ Liver Disorder
- ___ Cirrhosis
- ___ Hepatitis A
- ___ Hepatitis B
- ___ Hepatitis C
- ___ Irritable Bowel/Colon Disorder
- ___ Pancreatitis
- ___ Reflux/GERD
- ___ Ulcerative Colitis
- ___ Weight Loss Surgery
- ___ Other: ___________

Endocrine/Metabolic
- ___ Diabetes
  Type I or Type II
  Last A1C Reading: ______
- ___ Thyroid
- ___ Other: ___________

Eyes/Ears/Nose/Throat
- ___ Allergies
- ___ Cataracts
- ___ Glaucoma
- ___ Retinopathy
- ___ Other: ___________

Heart/Circulatory
- ___ Aneurysm
- ___ Angioplasty/Stent
- ___ Bypass
- ___ Congestive Heart Failure
- ___ Elevated Cholesterol
- ___ Heart Attack
  Date: ___________
- ___ Heart Disease
- ___ Heart Murmur
- ___ Heart Valve
- ___ High Blood Pressure
- ___ Irregular Heartbeat
- ___ Stroke
- ___ Other: ___________

Immune/Blood Disorder
- ___ AIDS/HIV
- ___ Anemia
- ___ Lupus
- ___ Other: ___________

Lung/Respiratory
- ___ Asthma
- ___ Chronic Bronchitis
- ___ COPD
- ___ Emphysema
- ___ Pneumonia
- ___ Sleep Apnea
- ___ Tuberculosis
- ___ Other: ___________

Mental Health/Substance Abuse
- ___ Alcoholism
- ___ Anxiety/Depression
- ___ Attention Deficiet Disorder
- ___ Bipolar/Manic Depression
- ___ Drug Abuse/Illegal Drug Use
- ___ Eating Disorder
- ___ Inpatient/Residential Treatment
- ___ Other: ___________

Reproductive
- ___ Abnormal Pap
  Date of last abnormal: _____
  Treatment: ___________
- ___ Abnormal Uterine Bleeding
- ___ Breast Disorder
- ___ Current Pregnancy
  Due Date: ___________
- ___ Past/Current Complications
- ___ Multiples Expected
- ___ Previous C-Section
- ___ Endometriosis
- ___ HPV/Condyloma
- ___ Ovarian Conditions
- ___ Sexually Transmitted Disease
- ___ Uterine Fibroids
- ___ Other: ___________

Transplant
- ___ Past Transplant(s)
  Organ: ___________
- ___ Possible Future Transplant
  Organ: ___________

Urinary/Kidney
- ___ Kidney Stones
- ___ Polycystic Kidney Disease
- ___ Prostate Disorder
- ___ Renal Failure
- ___ Bladder Disorder
- ___ Other: ___________

Other conditions/treatments not listed:
____
____

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 F 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 Insurance Company ("CHSIC"), 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 CHSIC, 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 CHSIC. 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. Pre-Existing Conditions: A Pre-Existing Condition exclusion may apply to any employee or dependent age 19 or older enrolling in a CHSIC PPO health plan. This exclusion can apply only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a pre-existing condition exclusion cannot last for more than twelve (12) months after your enrollment date. Finally, a pre-existing condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within thirty-one (31) days after birth, adoption, or placement for adoption.

   The Pre-Existing Condition exclusion may be waived if the employee or dependent was covered by a prior qualifying plan in certain situations. These provisions will be described in the Evidence of Coverage issued to the employee and will never be more restrictive than the applicable state and federal law.

5. Important Information: I understand no coverage under this insurance exists unless and until approved by Cox Health Systems Insurance Company, 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 CHSIC and understand that I am responsible for all charges incurred.

6. 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 CHSIC.

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:
   - ☐ Myself
   - ☐ Spouse
   - ☐ Dependent Child(ren)
   - ☐ Myself and all dependents

   Declining coverage due to existence of other coverage:
   - ☐ COBRA or State Continuation *
   - ☐ Coverage under Spouse's group plan *
   - ☐ Individual Health Plan *
   - ☐ I (we) have no other coverage at this time
   - ☐ Medicaid
   - ☐ Medicare or Champus (Tri-Care)
   - ☐ Other: ____________

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