

EMPLOYEE APPLICATION

Benefits

PPO _____
 OOA _____

Effective Date
Group #

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. Typed applications will not be accepted.

For members enrolled in the HealthAssurance PPO: HealthAssurance products are made available through HealthAssurance Pennsylvania, Inc. For out-of-area members enrolled in the 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 at 800-788-8445 in central and eastern PA and 800-735-4404 in western PA or contact your employer.

Employee Information *(Must be completed by employee)* Employee enrollment 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	Applicant/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 yours or your spouse's birth or legally adopted child, 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
	Employee							
	Spouse							

WAIVER *My employer has given me an opportunity to apply for group health coverage for myself and my dependents (if applicable)*

I have declined to apply for coverage for myself spouse dependents

Reason for decline: Other health insurance Spousal coverage Other reason (please explain)

I understand that if I decide to apply for health coverage for myself and any applicable dependents at a later date, neither my dependents nor I will be eligible for coverage until (1) my employer's next open enrollment period, or (2) there is a qualifying event as defined in the EOC/COI/GCSA.

Employee Signature (only if you are waiving coverage)

Date:

Authorization *I understand that my signature is mandatory on this release. This application will not be reviewed until this signature is 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 Preferred Provider Organization (PPO) coverage:** I understand that in the case of 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. **AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION.** I authorize any insurance company, physician, hospital, clinic, health care provider or other organization, institution or person having records or knowledge of anyone listed on this application to give HealthAmerica/HealthAssurance or their designated agent any and all records pertaining to any medical history, services or treatment provided to anyone on this application for purposes of review, investigation or evaluation of coverage. This authorization is valid as the original. I, the applicant, acknowledge that I have read and understand the Application in its entirety.

Signature of Employee

Date (MM/DD/YYYY)

Employee Name _____

Health Questionnaire

Health history of you and your family (include information about family members you wish to cover) – Has any person listed on this application ever 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.)*

- 1) Has any person listed on this application been hospitalized for any medical condition, chemical or substance abuse problem in the past two years? Yes No
- 2) Is any female to be covered under this policy currently pregnant? If currently pregnant have you had complications with current or past pregnancies? Yes No
Please provide due date and details below.

3) Have you or your enrolling family members ever been treated for:	Still under Treatment?	Date ended
• Any Cancer (including Hodgkin's or Leukemia) Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
• Hemophilia Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
• Multiple Sclerosis/ALS (Lou Gehrig's) Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
• Rheumatoid Arthritis or other connective tissue disorder Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
• Hepatitis Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
• Any Immune Deficiency disorder HIV/AIDS or Aids Related Complex (ARC) Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
• Diabetes Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
• Lyme Disease Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
• Chronic Back or Disc problems Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
• Coronary Artery Disease/Angio/CABG or stents Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____

If you answered yes to question 1, 2, or 3 or have any medical conditions not listed above please provide full details of treatment.

- 4) Please list any **prescription drugs, over the counter (OTC) drugs, and/or injectible medications** you or your enrolling family members are regularly taking or supposed to be taking.

Employee/ Dependent Name	Diagnosis	Drug Name	OTC Yes/No	Dosage	Frequency of Dose

Please use additional paper if necessary

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, applicant/family member(s) name: _____ Type of continuous coverage: Group Individual Other
Insurance Company: _____ Date Coverage Began: _____ Date Coverage Ended: _____
- C. 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.