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Ohio Uniform Small Group Employee Application

This uniform application is intended to simplify the health insurance application process when your employer has requested quotes from multiple carriers. Although one application is being used for multiple carriers, ultimately one carrier, selected by your employer, will provide the coverage.

Section A: Employer Information

Employer Name _____

Proposed Effective Date_____ Group Number (if known)_____

Section B: Employee Information

Last Name_____ First Name_____ MI____ Sex _____

Social Security _____ Date of Birth _____Height/Weight _____

Home Address _____

Home City _____ State _____ Zip _____ Phone _____

Work Address _____

Work City _____ State _____ Zip _____ Phone _____

Email Address _____

_____

Job Title _____ Full Time Date of Hire _____

Employment Status: ❍Full Time ❍Part Time ❍Retired

❒COBRA/State Continuation: Start Date _____ End Date _____

Hours Worked/Week _____ Salary $_____ per ❒Week ❒Month ❒Year ❒Other _____

Select all that apply: ❒Hourly ❒Salaried ❒Union ❒Non-Union

Marital Status: ❍Single ❍Married ❍Divorced ❍Widowed ❍Legally Separated

PCP Selection (if HMO or POS) _____ Are you an existing patient? ❍Yes ❍No

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

In completing this application and answering the question set forth herein, you should not include any of your or your dependent's family history or genetic information (including, but not limited to, genetic testing, genetic services, genetic counseling, or genetic diseases for which you and/or your dependents may be at risk.)

Section C: Family Information (Attach legal documentation for court-ordered dependents)

❐**Spouse**

Last Name____ First Name__________________________________ MI____ Sex _____

Social Security ___________________________Date of Birth ________________ Height___________ Weight ____________________

PCP Selection (if HMO or POS) ___________________________________ Are you an existing patient? ❍Yes ❍No

❍**Child** ❍**Stepchild** ❍**Other** ____

Last Name____ First Name__________________________________ MI____ Sex _____

Social Security ___________________________ Date of Birth ________________ Height___________ Weight ___________________

PCP Selection (if HMO or POS) ___________________________________ Are you an existing patient? ❍Yes ❍No

❐Different Last Name ❐Lives at another address ❐Disabled +26 ❐Full Time Student +26, please list

School Attending & Credit Hours ____

❍**Child** ❍**Stepchild** ❍**Other** ____

Last Name____ First Name__________________________________ MI____ Sex _____

Social Security ___________________________ Date of Birth ________________ Height__________ Weight ____________________

PCP Selection (if HMO or POS) ___________________________________ Are you an existing patient? ❍Yes ❍No

❐Different Last Name ❐Lives at another address ❐Disabled +26 ❐Full Time Student +26, please list

School Attending & Credit Hours ____

❍**Child** ❍**Stepchild** ❍**Other** ____

Last Name____ First Name__________________________________ MI____ Sex _____

Social Security ___________________________ Date of Birth ________________ Height_________ Weight _____________________

PCP Selection (if HMO or POS) ___________________________________ Are you an existing patient? ❍Yes ❍No

❐Different Last Name ❐Lives at another address ❐Disabled +26 ❐Full Time Student +26, please list

School Attending & Credit Hours ____

IMPORTANT: Please provide an address on a separate sheet for dependents that do not live with the employee. Please see your employer for more information on qualifications for full time student status.

Section D: Waiver of Coverage (Complete ONLY if you or your family are NOT enrolling)

I decline coverage for: ❒Myself ❒Myself & all dependents ❒My spouse ❒Dependent Children as follows

_____

I decline coverage due to: ❒Spouse's Employer Plan - Carrier & Group # _____

❒Individual Plan ❒Covered by Medicare ❒Covered by Medicaid ❒COBRA/State Continuation

I have other coverage: ❒VA Eligibility ❒Tri-Care ❒Other _____

❒I (we) have no other coverage at this time

❒I decline Medical coverage but request the following benefits offered by my employer _____

_____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a qualified life change event; or I apply at the next open enrollment period or as a late enrollee, if applicable.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other insurance coverage, you may be able to enroll yourself or your dependents in this plan if: (1) you or your dependents lose eligibility for that other coverage or (2) the employer stops contributing towards your or your dependents' other coverage. However, you must request enrollment within 31 days after the applicable event occurs (other coverage ends or employer's contribution ends).

If you or your dependent either become eligible for premium assistance or lose eligibility for coverage under the State Children's Health Insurance Program (SCHIP), you will also be able to enroll in this plan. However, you must request enrollment within 60 days after such an event. 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 that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Employee Signature _____ Date Signed _____

Section E: Coverage Selected

PRODUCT	Medical	Dental (if applicable)	Life Insurance (if applicable)	Short Term Disability (if applicable)	Long Term Disability (if applicable)	Waiver
Employee	❒	❒	❒	❒	❒	❒YES
Spouse	❒	❒	❒	❒	❒	❒YES
Dependents	❒	❒	❒	❒	❒	❒YES

For multiple options plans, please indicate plan selection below:

Medical _____ Dental _____

Section F: Beneficiary Designation (Must be completed if you applied for Life or AD&D insurance)

If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary (ies). If you list benefit percentages, the total must equal 100%. (The employee is the beneficiary of proceeds from spouse or child coverage.)

Beneficiary	Full Name	Relationship	Benefit Percentage
Primary			
Contingent			
Contingent			

Section G: Other Coverage Information

Does anyone identified on this application have current or prior coverage? ❍YES ❍NO
If yes, please provide proof of current coverage if you are waiving coverage or proof of prior coverage to ensure pre-existing condition credit. Acceptable forms of proof are:

1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of ID card or most recent payroll stub showing medical coverage deduction, or
3. Copy of most recent medical premium bill from prior carrier.

Failure to provide Proof of Prior Coverage may subject you or a family member age 19 or older to the full pre-existing conditions limitation with no credit for prior coverage. You may request a Certificate of Creditable Coverage from your prior carrier.
Please identify each person applying for coverage and include information for all current and previous health coverage(s) in effect during the last 18 months.

Applicant Name	Carrier Name	Group Number	Effective Date	Termination Date	Work Status
					❒Active ❒Retired
					❒Active ❒Retired
					❒Active ❒Retired
					❒Active ❒Retired
					❒Active ❒Retired

MEDICARE

Are you or any of your dependents covered by Medicare? ❍NO ❍YES, please attach a copy of your ID card

Medicare Beneficiary Name: _____

Medicare: Part A Effective Date _____ Part B Effective Date _____ Part D Effective Date _____

Reason: ❒Over 65 ❒Disabled ❒End Stage Renal Disease ❒Disabled but actively at work

Type: Medicare Part A? ❍YES ❍NO Medicare Part B? ❍YES ❍NO Medicare Part D? ❍YES ❍NO

Ineligible or Waived: Medicare Part A? ❍YES ❍NO Medicare Part B? ❍YES ❍NO Medicare Part D? ❍YES ❍NO

Employee Last Name_____ Employee First Name: _____

Employer: _____ Policy/Group#: _____ Section _____ Effective Date: _____

Section H: Medical Information

Have you or any other person listed on this application consulted with or been examined or treated by any health care professional during the last 5 years for any illness, injury or health condition in any of the categories listed below? If yes, please check the box that most appropriately describes the condition, record the specifics (if noted) and explain in detail on the table provided on page 12. **Please note, if you commit fraud or intentionally misrepresent a material fact, your coverage may be terminated, not renewed or premiums may be changed retroactively to the date your policy became effective.**

1. Heart/Circulatory/Vascular

❍ YES, check all that apply and record specifics (if noted) below
❍ NO

Condition	
❒Cardiac Ablation Date:_____	❒Congestive Heart Failure (CHF)
❒Anemia Type:_____	❒Elevated Cholesterol/Triglycerides
❒Aneurysm Location:_____ Operated: ❒YES ❒NO	❒Heart Attack/Disease (MI) Type:_____ Date:_____
❒Angioplasty/Stent Date:_____	❒Heart Murmur
❒Blood Clot/Thrombophlebitis Location:_____	❒Heart Valve Disorder
❒Blood Disorder Type:_____	❒Hemophilia
❒Bypass Date:_____	❒Hypertension/High Blood Pressure
❒CAD/Angina/Chest Pain	❒Irregular Heart Beat/Arrhythmia Date:_____
❒Carotid Artery Disease Operated: ❒YES ❒NO	❒Pacemaker/ICD Implant Date:_____
❒Peripheral Vascular Disease(PVD)	❒Stroke/CVA Date:_____
❒ Varicose Veins Operated: ❒YES ❒NO ❒NOT NEEDED	❒Stroke Deficits Type:_____ Date:_____
❒Other_____	

2. Brain/Nervous System/Neurological

❍ YES, check all that apply and record specifics (if noted) below
❍ NO

Condition	
❒Alzheimer's Disease	❒Neurological Disability Type:_____
❒ALS/Lou Gehrig's Disease	❒Muscular Dystrophy
❒Brain Injury Complications: ❒YES ❒NO	❒Paralysis Location: _____
❒Cerebral Palsy	❒Parkinson's Disease
❒Concussion	❒Seizures/Epilepsy Date Diagnosed: _____ Date of Last Seizure: _____ ❒Grand Mal ❒Petit Mal
❒Head Injury	❒Multiple Sclerosis/MS
❒Migraines Last Visit to ER: _____	❒Tumor/Growth/Cyst Location: _____
❒Other_____	

3. Birth Defects/Congenital Abnormalities

❍ YES, check all that apply and record specifics (if noted) below

❍ NO

Condition	
❒Cleft Palate/Lip	❒Premature Birth ❒Still Receiving Treatment
❒Club Foot	❒Skull/Facial Deformities
❒Developmental Delay	❒Other Physical Deformities
❒Down's Syndrome	❒Webbed Fingers/Toes
❒Heart Lung Malformation	❒Mental Retardation
❒Other_____	

4. Urinary/Kidney/Bladder

❍ YES, check all that apply and record specifics (if noted) below

❍ NO

Condition	
❒Bladder Disorder	❒Renal Failure/End Stage Renal Disorder Medicare Part A Eff. Date:_____ Medicare Part B Eff. Date:_____ Dialysis Start Date:_____
❒Kidney Disorders	❒Prostate Disorder Type:_____
❒Kidney Stone Date: _____ Present: ❒YES ❒NO Number of Stones Passed: _____	❒Tumor/Growth/Cyst Location:_____
❒Polycystic Kidney Disease	❒Other_____

5. Intestinal/Digestive

❍ YES, check all that apply and record specifics (if noted) below

❍ NO

Condition	
❒Pancreatitis	❒Gastric Bypass/Stapling
❒Colon Disorder	❒Gall Stones
❒Diverticulitis	❒Metabolic Disorder Type: _____ Operated: ❒YES ❒NO
❒Crohn's Disease Injections: ❒YES ❒NO	❒Reflux/GERD
❒Feeding Tube	❒Stomach Ulcer
❒Ilieostomy/Colostomy ❒Open ❒Closed	❒Tumor/Growth/Cyst Location: _____
❒Colon Resection ❒Total ❒Partial ❒Open ❒Closed	❒Ulcerative Colitis Injections: ❒YES ❒NO Operated: ❒YES ❒NO
❒Other_____	

6. Psychological

❍ YES, check all that apply and record specifics (if noted) below

❍ NO

Condition	
❒ADHD/ADD	❒Current Counseling
❒Alcohol Abuse	❒Drug Abuse ❒Cocaine ❒Heroin ❒Marijuana ❒Methadone ❒Morphine ❒Opiate ❒Prescription Drug ❒Other_____
❒Alcohol Suicide Attempt Date:	❒Inpatient Mental Health Stay
❒Anorexia	❒Schizophrenia
❒Autism	❒Suicide Attempt Date:_____
❒Anxiety/Depression	❒Bulemia
❒Bipolar/Manic Depression	❒Other_____

7. Lung/Respiratory

❍ YES, check all that apply and record specifics (if noted) below

❍ NO

Condition	
❒Allergies Injections: ❒YES ❒NO How Often: _____	❒Pneumonia Date: _____
❒Asthma ❒Mild ❒Moderate ❒Severe Date of Last ER Visit: _____	❒Sarcoidosis
❒Chronic Bronchitis Number of Episodes/Year: _____	❒Sleep Apnea C-PAP: ❒YES ❒NO
❒COPD/Emphysema Oxygen: ❒YES ❒NO ❒NOT NEEDED	❒Tuberculosis Date: _____
❒Cystic Fibrosis	❒Tumor/Growth/Cyst Location:_____
❒Other_____	

8. Cancer

❍ YES, check all that apply and record specifics (if noted) below

❍ NO

Condition	
❒Bone	❒Hodgkin's
❒Brain	❒Non-Hodgkin's
❒Breast	❒Metastasis to other organs
❒Cervical or Uterine	❒Ovarian
❒Colon	❒Prostate
❒Leukemia Type:_____	❒Testicular
❒Liver	❒Lymph Node Involvement
❒Lung	❒Chemotherapy Start Date: _____ End Date:_____
❒Lymphoma	❒Radiation Therapy End Date: Stage:
❒Other _____	❒Skin Type:_____

9. Ears/Eyes/Nose/Throat/Skin

❍ YES, check all that apply and record specifics (if noted) below

❍ NO

Condition	
❒Acne	❒Cochlear Implants
❒Acoustic Neuroma	❒Deafness
❒Burns ❒1st Degree ❒2nd Degree ❒3rd Degree	❒Deviated Septum
❒Cataracts Operated: ❒YES ❒NO ❒Right Eye ❒Left Eye	❒Eczema
❒Chronic Ear Infections Operated: ❒YES ❒NO	❒Glaucoma
❒Chronic Sinusitis	❒Psoriasis Injections: ❒YES ❒NO
❒Retinopathy	❒Tumor/Growth/Cyst Location:_____
❒Other_____	

10. Reproductive

❍ YES, check all that apply and record specifics (if noted) below

❍ NO

Condition	
❒Abnormal Pap Normal Follow Up Pap: ❒YES ❒NO Date: _____	❒Infertility Dates of Treatment: _____
❒Breast Cysts or Tumor	❒Menstrual Disorders
❒Breast Implants ❒Saline ❒Silicone	❒Polycystic Ovarian Syndrome
❒Current Pregnancy Due Date:_____(MM/DD/YYYY) ❒Multiples Expected ❒Complications thus far/High Risk ❒Prior History of Complications ❒Prior Cesarean Delivery ❒Cesarean Delivery Planned	❒Pregnancy Complications
❒Endometriosis	❒Sexually Transmitted Diseases
❒Human Papillomavirus	❒Other_____

11. Immune

❍ YES, check all that apply and record specifics (if noted) below

❍ NO

Condition	
❒Chromosomal Disorder Type: _____	❒Scleroderma
❒Immuno Deficiency	❒Other_____
❒Lupus ❒Discoid ❒SLE Systemic	

12. Bones/Muscles/Joint

❍ YES, check all that apply and record specifics (if noted) below

❍ NO

Condition	
❒Back/Neck Disorder Treatment: _____	❒Fracture ❒Pins/Screws/Plate ❒Permanent ❒Temporary
❒Bulging/Herniated Disc Treatment: _____	❒Joint Injury/Replacement Location:_____ Arthroscopy Date:_____ Replacement Date:_____
❒Chronic Fatigue Syndrome	❒Osteoarthritis
❒Congenital Problem	❒Osteoporosis
❒Degenerative Disc Disease	❒Physical Deformity
❒Fibromyalgia	❒Prosthetic Device Body Part: _____
❒Gout	❒Scoliosis
❒Implants Removed: ❒YES ❒NO	❒Spina Bifida ❒Occulta ❒Cystica
❒Arthritis Type:_____ Injections: ❒YES ❒NO	❒Tumor/Growth/Cyst Location: _____
❒Other_____	

13. Endocrine

❍ YES, check all that apply and record specifics (if noted) below

❍ NO

Condition	
❒Adrenal Gland	❒Hyperthyroid
❒Cirrhosis	❒Graves Disease
❒Diabetes Date Diagnosed: _____ Type: _____ ❒Diet ❒Insulin ❒Oral Medication ❒Other _____ Last 3 readings: _____ Complications: _____	❒Hashimoto Disease
❒Growth Hormones Date:_____	❒Liver Disorder Type: _____
❒Hepatitis ❒A ❒B ❒C ❒Other _____ Date:_____ Treatment:_____	❒Pituitary Disorder
❒Hypothyroid	❒Thyroid Disorder
❒Tumor/Growth/Cyst Location:_____	❒Other_____

14. Prescription Medication

❍ YES, check all that apply and record specifics (if noted) below

❍ NO

Condition	
❒Current Medication Please detail name, condition and dosage in the table provided on page 12	❒Medications Taken within the Past Year Please detail name, condition and dosage in the table provided on page 12

15. Transplant

❍ YES, check all that apply and record specifics (if noted) below

❍ NO

Condition	
❒Organ Type:_____ Date:_____	❒Other_____
❒Stem Cell ❒Planned/Recommended Date: _____	

16. Other

❍ YES, check all that apply and record specifics (if noted) below

❍ NO

Condition	
❒Abnormal Test Results (Excluding HIV/AIDS testing)	❒Chiropractor Adjustments
❒Abnormal Physical Results	❒Physical Therapy
❒Wheelchair Bound	❒Occupational Therapy
❒Uses of Crutches or Walker	❒Speech Therapy
❒Workers Compensation Injury Claim #:	❒Test Results Pending (Excluding HIV/AIDS testing)
❒Other_____ Type:	

17. Additional Medical Questions: Please explain full details for all "Yes" questions in the grid below.

For you or any person that will be covered, please respond and provide details in the table provided:

A. Within the last 5 years, has anyone been told they have any other condition not listed above? ❍YES ❍NO

B. Do any of the conditions identified above involve the Bureau of Worker's Compensation? ❍YES ❍NO

If YES, please include the claim number _____

C. Has anyone been advised to have surgery and/or further treatment NOT yet performed? ❍YES ❍NO

D. Has anyone been diagnosed with HIV/AIDS? ❍YES ❍NO

E. Has anyone received a positive test result for HIV/AIDS? ❍YES ❍NO

F. Is anyone expecting to be the parent of a child expected to be born in the next 9 months? ❍YES ❍NO

G. Does anyone currently use tobacco products? ❍YES ❍NO

H. Has anyone been hospitalized in the past 24 months? ❍YES ❍NO

If you have checked "yes" to any conditions on previous pages, have any other medical conditions, or anticipate a future surgery or procedure not listed above, please explain below.

Please give FULL DETAILS for all "YES" answers. If necessary, please attach, date, and sign additional pages for medical explanation details.

Question Number	Applicant Name	Condition/Diagnosis: Include start date	Treatment: Include dates	Names of Medications: all varieties	Ongoing Treatment	Physician's Name

Section I: Authorization and Certification

•In connection with this application for coverage with the carrier(s) identified below, I certify that I have read, or have had read to me, this completed form, and I realize that any act of fraud or intentional misrepresentation of a material fact in this form may result in a loss or rescission of coverage. I acknowledge that all claims relating to such acts will become my responsibility if incurred after termination or effective date of rescission.

•I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, carrier's HMO or other organization, institution or person that has any knowledge of my health or the health of my spouse, dependents and/or eligible adult-age children as listed on this form to disclose such information to the extent permitted by law to the carrier(s) for the purpose of compiling an accurate evaluation of the medical information provided in section H and to establish premium rates for the group.

•I understand and acknowledge that this authorization extends to all medical records, including records which may contain information regarding treatment for physical and mental illness, alcohol/drug use and/or HIV-AIDS test results or diagnosis. I expressly consent to the release of such information.

•I understand the authorization signed for the purpose of collecting information in connection with this application for an insurance policy shall remain valid for thirty (30) months from the date shown below. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.

•I understand that I may be contacted by the carrier to obtain additional follow-up information on health conditions disclosed in this document for me, my spouse, dependents, and/or eligible adult-age children.

•I understand and agree that the carrier(s) identified below, will rely upon the information provided in this application as the basis for establishing group premium rates for health care coverage. I also acknowledge that I may be required to complete and sign an Additional Authorization and Disclosure Form for the carrier selected by my employer.

Check name of carrier:

❍Aetna ❍AultCare ❍HealthAmerica ❍Medical Mutual of Ohio ❍Paramount ❍The Health Plan of the Upper Ohio Valley
❍UnitedHealthcare ❍SummaCare / Summa Insurance Company ❍Other _____

The carrier name section must be completed in its entirety prior to the employee and spouse signatures. Please list additional carriers above.

Print Employee Name: _____
Employee Signature: _____ Date: _____
Print Spouse Name: _____
Spouse Signature: _____ Date: _____
(If applicable & available)

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.