



Important Reminders for Completing the Employee Application

ENROLLING IN PLAN

In order to ensure your application for coverage is processed timely, *please complete the following information on the application in its entirety.*

- Page 1 - Complete the Employee section at the top of the page; if you are enrolling one or more of your family members on the plan please be sure to complete the dependent section at the bottom of the page.
- Page 2 - If you are not enrolling one or more of your family members in the plan please complete, sign and date the EMPLOYEE DEPENDENT WAIVER OF COVERAGE. *Remember if you choose to not enroll your family members at this time you will have to wait until the your employer's next open enrollment period, 1 year from now, unless there is a qualifying event.*
- Page 3 – Please be sure to list a Primary Care Physician
- Page 7 – Remember to sign & date

WAIVING COVERAGE

If you are waiving coverage for yourself, you still need to complete the following section of the application:

- Page 2 - Complete & sign the EMPLOYEE/DEPENDENT WAIVER OF COVERAGE for you and any of your family members (spouse &/or children). *Remember if you choose to not enroll you and your family members at this time you will have to wait until your employer's next open enrollment period, 1 year from now, unless there is a qualifying event.*



COLORADO CHOICE HEALTH PLANS EMPLOYEE APPLICATION FOR LARGE GROUP COVERAGE

Employee Name:	Employer Name:
Proposed Effective Date:	Group Number (if known):

This form is designed for an employee's initial application for coverage.

EMPLOYEE & DEPENDENT INFORMATION

Employee Instructions: Please **type or print** using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought.

Last Name:	First Name:	Middle Initial:
Social Security Number:	Date of Birth: / /	Sex: Height: Weight:
Address:	City:	County: State: Zip:
Home Phone:	Work Phone:	Email: <input type="checkbox"/> Home <input type="checkbox"/> Work
What is your job title at your current employer?		
What was your first day of employment?		How many hours, on average, do you work each week?
Are you (check one):		
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law* <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow or Widower		
* A common law certification may be required by the carrier		
Are you on COBRA or State Continuation? <input type="checkbox"/> Yes <input type="checkbox"/> No Start Date: Stop Date:		

List all dependents, spouse and child(ren), applying for coverage. If you need additional space, please use a separate sheet of paper and attach it to this application (please print your name and sign and date the additional sheet).

Name (Last, First, MI)	Sex	Social Security Number	Relationship	Birth Date	Height	Weight	Dependent Information*
			Spouse	/ /			
(Dependent 1)			<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____	/ /			<input type="checkbox"/> Full Time Student (Over Age 19 Under 24) <input type="checkbox"/> Financially Dependent or Same Household (Over Age 19 Under 25) <input type="checkbox"/> Disabled (Indicate reason) (Over Age 19) _____
(Dependent 2)			<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____	/ /			<input type="checkbox"/> Full Time Student (Over Age 19 Under 24) <input type="checkbox"/> Financially Dependent or Same Household (Over Age 19 Under 25) <input type="checkbox"/> Disabled (Indicate reason) (Over Age 19) _____
(Dependent 3)			<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____	/ /			<input type="checkbox"/> Full Time Student (Over Age 19 Under 24) <input type="checkbox"/> Financially Dependent or Same Household (Over Age 19 Under 25) <input type="checkbox"/> Disabled (Indicate reason) (Over Age 19) _____

* If you check any of the boxes in this section Colorado Choice Health Plans may require additional information to determine eligibility of the dependent.



Employee Name:	Employer Name:
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EMPLOYEE/DEPENDENT WAIVER OF COVERAGE

Complete this section **ONLY** if you are not enrolling yourself or your spouse or dependents. Waiver must be completed for all of your dependents to be eligible for enrollment on this plan in the event of changing circumstances. I understand that I am eligible to apply for group health coverage through my employer. I do **NOT** want, and hereby waive, group health coverage for:

	Name (Last, First, MI)	Birth Date (Mo/Day/Year)	Coverage Waived					
Employee			<input type="checkbox"/> All	<input type="checkbox"/> Medical				
Spouse			<input type="checkbox"/> All	<input type="checkbox"/> Medical				
Dependent 1			<input type="checkbox"/> All	<input type="checkbox"/> Medical				
Dependent 2			<input type="checkbox"/> All	<input type="checkbox"/> Medical				
Dependent 3			<input type="checkbox"/> All	<input type="checkbox"/> Medical				

I am **waiving** group health coverage because (check all that apply, **copy of ID card may be required**):

- I am covered under my spouse's group policy.
- My spouse is covered under another plan (including this plan, if spouse is also an employee).
- My dependents are covered under another plan.
- I wish to continue other coverage obtained through an Individual Plan or Medicare
- Other (Please explain): _____

WAIVER: I certify that I have been given the opportunity to apply for group health coverage and decline to enroll as indicated above, on behalf of myself, my spouse and my dependent child(ren). I understand that by signing this waiver, I, my spouse, and my dependent child(ren) forfeit the right to coverage. I was not pressured, forced or unfairly induced by my employer, the agent or the carrier(s) into waiving or declining the group health coverage. If in the future I apply for coverage, I, my spouse, or any of my dependent child(ren) may be treated as a late enrollee and subject to postponement of coverage for up to 12 months or an exclusion of coverage for preexisting conditions for a period of up to 18 months. Any preexisting condition period may be offset by the time I, my spouse or my dependent child(ren) were covered under a qualified health plan.

I understand that if I am declining enrollment for myself, my spouse, or my dependent child(ren) because of other health coverage, I may, in the future, be able to enroll myself, my spouse, or my dependent child(ren) in this plan, as required by law, provided that I request enrollment within 30 days after my other health coverage ends. In addition, if I gain a dependent spouse or child(ren) as a result of marriage, birth, adoption, or placement for adoption, I understand that I may be able to enroll myself, my spouse and my dependent child(ren), provided that I request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. **If I do not request enrollment within 30 days of the above events, I understand that I may not be able to enroll for coverage until my company's Open Enrollment period. I understand that I can obtain information related to my enrollment eligibility from my employer or group health carrier.**

Signature of Employee: _____

Date Signed: _____

Employee Name:	Employer Name:
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ENROLLMENT SELECTIONS

Please select the type of coverage for which you are applying from the plans offered by your employer and issued by the carrier.

Employee: <input type="checkbox"/> Medical Medical Plan Name: Primary Care Physician Name: Primary Care Physician Address:
Spouse: <input type="checkbox"/> Medical Medical Plan Name: Primary Care Physician Name: Primary Care Physician Address:
Dependent 1: <input type="checkbox"/> Medical Medical Plan Name: Primary Care Physician Name: Primary Care Physician Address:
Dependent 2: <input type="checkbox"/> Medical Medical Plan Name: Primary Care Physician Name: Primary Care Physician Address:
Dependent 3: <input type="checkbox"/> Medical Medical Plan Name: Primary Care Physician Name: Primary Care Physician Address:

If you, your spouse or your dependent(s) are electing to enroll in DENTAL coverage, please complete the following:

Within the past 12 months, have you, your spouse, or your dependent child(ren) had any individual or other group dental coverage? N/A
 Yes No If you answered "Yes," please provide the following information:

Dental Carrier Name: Policy Number: Phone Number:
Address:
Coverage Effective Date: Coverage Termination Date:
Is coverage still in effect? Yes No Orthodontia coverage? Yes No
Who was or is covered under the policy listed above?
Evidence of prior coverage maybe requested

Employee Name:	Employer Name:
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CURRENT AND PREVIOUS MEDICAL COVERAGE

The information you provide about your other individual or group health coverage (either prior or current) is necessary to determine whether you will have any waiting periods for preexisting conditions under the group health coverage plan for which you are applying for coverage. Your information will also help the employer carrier(s) to coordinate benefits with any other group health coverage you may have.

Do you, your spouse or your dependent child(ren) listed in this application have current health coverage or had previous health coverage within the last 90 days? Yes No

If "Yes," please complete the following table and attach a copy of the Certificates of Creditable Coverage for each person. Starting with you, the employee, identify each person applying for coverage and include information for all current and previous health coverage(s) in effect during the last 18 months.

Employee Name:	Date Coverage Started:	Date Coverage Ended:
Carrier Name:	Carrier Phone Number:	Type of Coverage (See Key):
Group Number:	Subscriber ID #:	Reason for Termination:
Is Current Coverage an HSA qualified High Deductible Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Spouse Name:	Date Coverage Started:	Date Coverage Ended:
Carrier Name:	Carrier Phone Number:	Type of Coverage (See Key):
Group Number:	Subscriber ID #:	Reason for Termination:
Is Current Coverage an HSA qualified High Deductible Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Dependent Names:	Date Coverage Started:	Date Coverage Ended:
Carrier Name:	Carrier Phone Number:	Type of Coverage (See Key):
Group Number:	Subscriber ID #:	Reason for Termination:
Is Current Coverage an HSA qualified High Deductible Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Type of Coverage Key: G = Group Comprehensive Major Medical; I = Individual Comprehensive Major Medical; MS = Medicare Supplement; H = Hospital Coverage Only; V = Vision Coverage Only O=Other, please explain: _____

MEDICARE INFORMATION

If you need to complete this section for more than one person, please use a separate sheet of paper and attach it to this application (please sign and date the additional sheet). A copy of your ID card may be required.

Are you, your spouse or your child(ren) covered by:		
Medicare Part A? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Part D? <input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," reason for Medicare:		
<input type="checkbox"/> 65+	<input type="checkbox"/> Disability	<input type="checkbox"/> End-Stage Renal Disease (ESRD) Eff. Date _____
		<input type="checkbox"/> Disability and ESRD Eff. Date _____
Name of person covered by Medicare: _____		

Employee Name:	Employer Name:
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MEDICAL INFORMATION

**CAN BE MAILED DIRECT TO:
 COLORADO CHOICE HEALTH PLANS / SLVHMO, Attn: Medical Dept., 700 Main St, #100, Alamosa, CO 81101**

You are NOT required to share this information with your employer. You may, at your discretion, return this completed application in a sealed envelope. Please write your name on the outside of the envelope for easy identification.

Please answer the following questions to the best of your knowledge. On the next page, please provide the complete details if you answer "Yes" to any of the questions below. The date that this application is signed is the date which you should use when answering questions that request you to provide prior history for a period of time.

This health questionnaire must be updated to include any change in health status that occurs between the date of application and the effective date.

Are you, your spouse or any dependent child(ren) currently pregnant or an expectant parent?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," please indicate due date:	Twins or Other Multiple(s) Expected? <input type="checkbox"/> Yes <input type="checkbox"/> No
Complications? <input type="checkbox"/> Yes <input type="checkbox"/> No	C-Section Expected? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has anyone named in this application been treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has anyone named in this application used tobacco products during the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes," please complete the following:	
Name (s):	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Pipe/Cigars
Duration?	Frequency?
In the past 5 years, has anyone named in this application been evaluated or treated for alcoholism or chemical dependency; or joined any organization for alcoholism or chemical dependency; or used illegal drugs; or been advised by a health care professional to reduce the use of alcohol or illegal drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
In the past 5 years, has anyone named in this application sustained an injury as a result of an auto or work related accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Within the past 5 years, has anyone applying for coverage been counseled, or consulted or treated for any of the following:	
1. Heart disease or disorder, stroke, circulatory disorder, chest pain, high or low blood pressure, anemia or blood disorder, elevated cholesterol and or/triglyceride levels or any other circulatory system issue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Ulcers, stomach disorder, liver/pancreas disorder, hernia, gallbladder disorder, rectal disorder, intestine disorder, esophageal disorder, hepatitis, colitis, Crohn's disease or any other digestive system issue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Urinary tract/kidney/bladder disorder, prostate disorder, renal failure, menstrual disorder, genital disorder, sexual dysfunction, infertility, dialysis, sexually transmitted disease, pregnancy complications (e.g., premature birth, miscarriage, C-Section), breast disorder or other genitourinary system issue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Connective tissue disorder, thyroid disorder, adrenal disorder, diabetes, enlargement of the lymph-nodes, lymph system disorder, endocrine disorder, any growth disorder or other endocrine system issue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Allergy(ies), asthma, emphysema, sinus or nasal disorder, lung disease or disorder, shortness of breath, sleep apnea or other respiratory system issue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Arthritis, fibromyalgia, back/neck disorder, joint /bone disorder, knee disorder, carpal tunnel, skin disorder, chronic fatigue syndrome or other musculoskeletal issue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Brain disorder, aneurysm, paralysis, central nervous system disorder, cerebral palsy, epilepsy or other seizures, headaches, multiple sclerosis or other nervous system issue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Cancer, tumor, abnormal growth, cyst or carcinoma-in-situ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Eye or ear disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Attention deficit disorder, psychological disorder, suicide attempt, depression, anxiety, autism or other behavioral health issue or biologically based mental illness (schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, panic disorder)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Organ or other type of transplant or implant (including breast implants), gastric bypass, physical deformity or defect including cleft lip or cleft palate, prosthetic device, congenital disorder, down's syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Within the last 5 years, has anyone named in this application to be covered by this coverage had any other injury, illness or treatment for any condition not already listed; been hospitalized or been scheduled for hospitalization; has surgery or had surgery scheduled; had a test or a test scheduled; or been recommended to have a test or surgery which was not performed for any reason not already mentioned in this application? We are NOT seeking the results of HIV Antibody Test. <input type="checkbox"/> Yes <input type="checkbox"/> No	

Employee Name:	Employer Name:
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If you answered, "Yes" to any of the questions or conditions on the previous page please list and provide the complete details in the space provided below.

(Attach additional pages as needed. Please print your name and sign and date the additional pages.)

Name of Person	Date(s) of Treatment	Question Number	Give full details for each question answered "Yes," state the condition, duration and degree of recovery. If accident or injury, also indicate if auto or work related.	Name and address of attending physician or other health care provider.

Not Applicable (no pre-existing)

If anyone named in this application is taking medication or was prescribed or recommended any medication during the period of time related to your answer (i.e. past 5 years or currently taking), please list all of those medications, dosages, and what medical condition is being treated or were treated by each medication in the space provided below.

(Attach additional pages as needed and sign and date the additional pages.)

Name of Person	Name, dosage and frequency of medication <i>(include illness or health condition for which medication was prescribed)</i>	Date(s) medication taken <i>(indicate if ongoing)</i>	Name and address of prescribing physician or licensed health care provider

Employee Name:	Employer Name:
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TERMS AND CONDITIONS

I acknowledge that I have read all sections of this Employee Application for Employer Group Health Coverage (Application), and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge. I understand and agree that neither my employer nor any insurance agents have any authority to waive my complete answer to any question, agree to insurability, alter any contract, or waive any Colorado Choice Health Plans rights or requirements.

I hereby apply for enrollment for myself and for my eligible family dependents listed. On behalf of my eligible family dependents and myself, I agree to all of the terms and conditions of the group contract(s) with Colorado Choice Health Plans under which I wish to enroll for coverage. I have indicated in this Application, if required, what product(s) or provider(s) I have selected. **I agree that no coverage will be effective until the date specified by Colorado Choice Health Plans , after this application has been accepted by Colorado Choice Health Plans .**

I understand and agree that any information obtained in connection with this Application will be used by Colorado Choice Health Plans to determine eligibility for coverage, underwriting and for any other purposes related to providing coverage. On behalf of my eligible family dependents and myself, I authorize any provider of health services or supplies, insurance company, health care clearinghouse (MIB or other), pharmacy benefit manager, and any other person with knowledge or records to release information to any Colorado small employer carrier, its agents and legal representatives, about any and all health-related services and supplies provided or to be provided to me or my eligible family dependents.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

When applicable, I authorize my employer to deduct contributions from my earnings to be applied to the cost of coverage.

I agree to any applicable group contract provisions for the resolution of disagreements and disputes, including arbitration when required and as allowed by law. Please refer to any arbitration provisions in the group contract(s).

I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document will become a part of the contract when coverage is approved and issued.

Signature of Employee: _____ **Date Signed:** _____

Employee Name:	Employer Name:
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DISCLOSURES

Preexisting Conditions

A preexisting condition means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within six (6) months preceding the date of enrollment or, if earlier, the first day of the waiting period for enrollment.

A preexisting condition limitation provision does not apply to pregnancy, a newly adopted child, a child placed for adoption, nor to a child who is enrolled within 30 days after birth.

If the health benefit plan for which you are enrolling has a preexisting condition limitation provision, the following statements apply:

- This limitation period shall be no longer than six (6) months (12 months for business groups of one) for all new enrollees.
- For late enrollees, the limitation period may be up to 18 months.

The preexisting condition limitation period will be reduced by the period of time that a new enrollee was covered by creditable coverage, provided that the creditable coverage did not terminate more than 90 days before the earlier of the first day of the waiting period or the effective date of coverage. The health coverage policies or plans that count as "creditable coverage" can reduce the length of a preexisting condition limitation period depending on the amount of time the new enrollee was covered by the creditable coverage.

Late Enrollee

A late enrollee is an eligible employee or dependent who requests enrollment in a group health benefit plan following the initial enrollment period for which the individual was entitled to enroll under the terms of the health benefit plan, as long as the initial enrollment period was a period of at least 30 days.

Creditable Coverage

Creditable coverage as defined in § 10-16-102(13.7), C.R.S., means benefits or coverage under:

- Medicare or Medicaid;
- An employee welfare benefit plan or group health insurance or health benefit plan;
- An individual health benefit plan; a state health benefits risk pool (including but not limited to CoverColorado); or
- Coverage provided under Chapter 55 of title 40 of the United States code, a medical care program of the federal Indian health service or of a tribal organization, a health plan offered under chapter 89 of title 5, United States code, a public health plan, or a health benefit plan under section 5(e) of the federal "Peace Corps Act" (22 U.S.C. Sec 2504(e)).

Not Applicable (no pre-existing)