COLORADO UNIFORM EMPLOYEE APPLICATION FOR SMALL GROUP HEALTH BENEFIT PLANS

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

This form is designed for an employee's initial application for coverage. Please contact your agent or the carrier to determine if this form should be used in other situations once the group is enrolled with the carrier.

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 #:		Date of Birth:	/ /	Sex:		Height:		Weight:			
Address:				City:							
County:		State:				Zip:					
Home Phone:		Email:				☐ Home		☐ Work			
What is your job title at your current employer?				Work Phone:							
What was your first day of employment?		How many hours, on average, do you work each week?									
Are you (check one):	☐ Single	☐ Married	☐ Common Law*	☐ Legally Separated	☐ Divorced	☐ Widow or Widower					
* A common law certification may be required by the carrier											
Are you on COBRA or State Continuation?	☐Yes	☐ No	Start Date:		Stop Date:						
Please select the type of coverage for which you are applying from the plans offered by your employer and issued by the carrier:											
Medical Plan Name:		Primary Care Physician Name:									
Primary Care Physician Address:											

List all dependents (spouse and child(ren)) applying for coverage. Please list the medical plan for which you are applying from the plans offered by your employer and issued by the carrier. 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).

Spouse Name:		Relationship:	Spouse								
Social Security #:		Date of Birth:	/ /	Sex:		Height:		Weight:			
Medical Plan Name:		Primary Care Physician Name:									
Primary Care Physician Address:											
Dependent Name:		Relationship:	☐Child ☐Stepchild ☐Other_____								
Social Security #:		Date of Birth:	/ /	Sex:		Height:		Weight:			
Medical Plan Name:		Primary Care Physician Name:									
Primary Care Physician Address:											
Please check all that apply for the Dependent listed above*: ☐ Full Time Student (Over Age 19 Under 24) ☐ Financially Dependent or Same Household (Over Age 19 Under 25) ☐ Disabled (Indicate reason) _____ (Over Age 19)											
Dependent Name:		Relationship:	☐Child ☐Stepchild ☐Other_____								
Social Security #:		Date of Birth:	/ /	Sex:		Height:		Weight:			
Medical Plan Name:		Primary Care Physician Name:									

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

This section continued on the next page…

Employee Name:	Employer Name:

Primary Care Physician Address:									
Please check all that apply for the Dependent listed above*: ☐ Full Time Student (Over Age 19 Under 24) ☐ Financially Dependent or Same Household (Over Age 19 Under 25) ☐ Disabled (Indicate reason) _____ (Over Age 19)									
Dependent Name:		Relationship:	☐Child ☐Stepchild ☐Other_____						
Social Security #:		Date of Birth:	/ /	Sex:		Height:		Weight:	
Medical Plan Name:		Primary Care Physician Name:							
Primary Care Physician Address:									
Please check all that apply for the Dependent listed above*: ☐ Full Time Student (Over Age 19 Under 24) ☐ Financially Dependent or Same Household (Over Age 19 Under 25) ☐ Disabled (Indicate reason) _____ (Over Age 19)									

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

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)
Employee		
Spouse		
Dependent 1		
Dependent 2		
Dependent 3		

I am **waiving** group health coverage for myself and/or the dependents listed above 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 or a qualifying event occurs. **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 small group health carrier.**

Signature of Employee: _____ Date Signed: _____

Employee Name:	Employer Name:

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. Your information will also help the small employer carrier(s) to coordinate benefits with any other group health coverage you may have.

#1 Do you, your spouse or your dependent child(ren) listed in this application currently have health coverage?
☐Yes ☐No

#2 Have you, your spouse or your dependent child(ren) listed in this application had previous health coverage within the last 90 days? ☐Yes ☐No

If you marked question #2 "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.

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).

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?			☐ Yes ☐ No				
Is the plan information listed above the same for your spouse and all dependents? If yes, skip to next section. ☐ Yes ☐ 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?			☐ Yes ☐ 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?			☐ Yes ☐ 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? ☐Yes ☐No		Medicare Part B? ☐Yes ☐No	Medicare Part D? ☐Yes ☐No
If "Yes," reason for Medicare:			
☐ 65+	☐Disability	☐ End-Stage Renal Disease (ESRD) Eff. Date_____	☐ Disability and ESRD Eff. Date_____
Name of person covered by Medicare:			

Employee Name:	Employer Name:

MEDICAL INFORMATION

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?						☐ Yes	☐ No	
If "Yes," please indicate due date:			Twins or Other Multiple(s) Expected?			☐ Yes	☐ No	
Complications?	☐ Yes	☐ No	C-Section Expected?	☐ Yes	☐ No			
In the past 5 years, 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)?						☐ Yes	☐ No	
Has anyone named in this application used tobacco products during the past 12 months?						☐ Yes	☐ No	
If "Yes," please complete the following:								
Name (s):				☐ Cigarettes	☐ Chewing tobacco	☐ 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?						☐ Yes	☐ 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?						☐ Yes	☐ 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?	☐ Yes ☐ 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?	☐ Yes ☐ 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?	☐ Yes ☐ No
4.	Connective tissue disorder, thyroid disorder, adrenal disorder, diabetes, enlargement of the lymph-nodes, lymph system disorder, pituitary disorder, any growth disorder or other endocrine system issue?	☐ Yes ☐ No
5.	Allergy(ies), asthma, emphysema, sinus or nasal disorder, lung disease or disorder, shortness of breath, sleep apnea or other respiratory system issue?	☐ Yes ☐ No
6.	Arthritis, fibromyalgia, back/neck disorder, joint /bone disorder, knee disorder, carpal tunnel, skin disorder, chronic fatigue syndrome or other musculoskeletal issue?	☐ Yes ☐ No
7.	Brain disorder, aneurysm, paralysis, central nervous system disorder, cerebral palsy, epilepsy or other seizures, headaches, multiple sclerosis or other nervous system issue?	☐ Yes ☐ No
8.	Cancer, tumor, abnormal growth, cyst or carcinoma-in-situ?	☐ Yes ☐ No
9.	Eye or ear disorder?	☐ Yes ☐ 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)?	☐ Yes ☐ 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?	☐ Yes ☐ 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; had 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.*	☐ Yes ☐ No

Employee Name:	Employer Name:

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.

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 (*include illness or health condition for which medication was prescribed*)	Date(s) medication taken (*indicate if ongoing)*	Name and address of prescribing physician or licensed health care provider

Employee Name:	Employer Name:

TERMS AND CONDITIONS

I acknowledge that I have read all sections of this Colorado Uniform Employee Application for Small 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 small employer carrier's other 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 small employer carrier(s) 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 the Colorado small employer carrier(s) with whom I enroll, after this application has been accepted by such carrier(s)**.

I understand and agree that any information obtained in connection with this Application will be used by Colorado small employer carrier(s) 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, 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:

DISCLOSURES

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.

Please be advised that a carrier may not request or require medical information going back more than five (5) years before the date of application. Additionally, the carrier cannot use medical information that is more than five (5) years old on any of the enrollee members of a small group in underwriting or setting premiums for the group.

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.

A preexisting condition limitation provision **DOES NOT** apply to any of the mandated Colorado basic or standard HMO health benefit plans.

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 10 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)).

This document is a publication of the Colorado Division of Insurance. If you have questions about the content of this document please contact our offices at 303-894-7499 or visit our website at http://www.dora.state.co.us/insurance. For questions regarding coverage or enrollment please see your employer.

Employee Name:	Employer Name:

This page may be used to provide additional information that was required in the sections above and did not fit in the space provided.

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