Employee Application for Group Health Insurance *PPO 51+*

Cox Health Systems Insurance Company
3200 South National, Building B • Springfield, Missouri 65807 • (417) 269-4679

Cox HealthPlans
CoxHealth

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 ballpoint 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:
   Work Phone: | Home/Cell Phone: | Preferred Language: | Ethnicity:
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 J)*

1. ❑ New Subscriber
   ❑ Add Dependents (List Below)
   ❑ Terminate Dependents (List Below)
   ❑ Address Change
   ❑ Name Change
   ❑ Plan Change ❑ Retiree
   ❑ COBRA/State Continuation: Continuation Start Date: _____
   ❑ Special Enrollment: Qualifying Event Type: _____
   Qualifying Event Date: _____

Section C: Product and 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
				M F				Y N

Employee Name: _____ SSN: _____

ENROLL/ CHANGE /TERM	LEGAL NAME	RELATIONSHIP	SOCIAL SECURITY #	GENDER	BIRTH DATE	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
				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.)*

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 five years?	❑ Yes*	❑ No
4	In the last five years, have you had any abnormal test or physical 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 Deficit 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(s)
  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 E 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

If Medical Information Has Been Entered it Will Appear on the Following Pages

Section G: Medica

Legal Name (Last,				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 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.
A photographic copy of this consent shall be 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 (2) 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 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 **Important Information**: I understand no coverage under this insurance exists unless and until approved by CHSIC 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.

5 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: Electronic Consent *(optional)*

1 I understand and consent to receiving plan documents or notices delivered by electronic means. I understand I have the right to delivery of these documents or notices in paper form at no additional cost upon request. I understand I have the right to withdraw consent to have these documents or notices delivered by electronic means upon verbal request to Cox HealthPlans, LLC by contacting the Member Service Department. These documents are always available on the Member Portal located on our website at www.coxhealthplans.com or by calling 800-205-7665 for the information to be mailed. Electronic delivery will require e-mail and Internet capability.

Please initial and clearly print your e-mail address: _____ Initial Here: _____

Section J: 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 **If Waiving Coverage, Information Has Been Entered it Will Appear on the Following Page(s)**

2 **If Prior Insurance Information Has Been Entered it Will Appear on the Following Page(s)**

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 of 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 31 days within which to submit the required forms to enroll, that begins on the date of the qualifying event.

X _____ _____

Signature of Enrolling Employee *(sign only if waiving coverage)* **Date Signed**