Employee Application for Group Health Insurance *PPO 2–50*

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.
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/Race *(optional)*:

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 G)*

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

SECTION E: DEPENDENT INFORMATION

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
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				☐M ☐F				☐Y ☐N

Section E: 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 Cox Health Systems Insurance Company, Inc. at its home office in Springfield, Missouri.

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 F: 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 and requesting 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 G: Waiver of Coverage *(If you are waiving coverage for any reason, including other coverage, you must complete this section, Section A, 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**