NEBRASKA UNIFORM GROUP HEALTH APPLICATION

EMPLOYER DATA

Employer ________________________________ Group Number ______________________________ Phone ______________________
Street Address ________________________ City ____________________ State ________ Zip ____________ Fax ________________________

EMPLOYEE DATA

Employee Name __________________________________ Social Security Disabled? Y N Medicare Enrolled? Y N Sex: M F
Home Address ____ City _________________ State ______ Zip __________
Work Phone # ________________________ Home Phone # _______________________ Email ______________________________________
DOB ________ Height ______ Weight ______ Social Security _______________________ Job Title ___________________ Date of Hire ________
Primary Care Physician ____
Average Hours Worked per Week _______ Salary/Wage $ __________ Employment Status: ☐Full-Time ☐Part-Time ☐Retired ☐COBRA
Marital Status: ☐Married ☐Single ☐Divorced ☐Legally Separated ☐Widowed

WAIVER OF COVERAGE

I decline coverage for:		Declining coverage due to existence of other coverage:	
☐ Medical	☐ Self	☐ Spouse's Employer's Plan	☐ Individual Plan
☐ Dental	☐ Spouse	☐ Covered by Medicare	☐ VA Eligibility
☐ Life	☐ Children	☐ COBRA from prior employer	☐ Tri-Care
☐ Vision	☐ Family	☐ I (we) have no other coverage at this time	☐ Medicaid
☐ Disability		☐ Disability	☐ Other, explain:

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a late enrollee, if applicable. I also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.

Signature ____ **Date Signed** ______________________

COVERAGE SELECTED

Please indicate your coverage choice - *Note: All coverages may not be available from all carriers*

Medical	☐ Employee	☐ Employee/Spouse	☐ Employee/Child(ren)	☐ Employee/Spouse/Child(ren)
		Plan selection ☐ PPO	☐ HDHP	☐ Other, define:
Dental	☐ Employee	☐ Employee/Spouse	☐ Employee/Child(ren)	☐ Employee/Spouse/Child(ren)
Life	☐ Employee	☐ Employee/Spouse	☐ Employee/Child(ren)	☐ Employee/Spouse/Child(ren)
Vision	☐ Employee	☐ Employee/Spouse	☐ Employee/Child(ren)	☐ Employee/Spouse/Child(ren)
Disability	☐ Employee/Short Term		☐ Employee/Long Term	

DEPENDENT DATA

Name (First, MI, Last)	Sex	Height	Weight	Birth date	Social Security Number	Primary Care Physician	Full-Time Student	Medicare Enrolled?	Social Security Enrolled?
Spouse	☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent	☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent	☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent	☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent	☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent	☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

OTHER COVERAGE

Medicare Coverage:	**Previous Coverage:**
Name:_____ ID#:_____ Effective Date (Part A)_____(Part B)_____ (Part C)_____ **Concurrent Coverage:** Will you, your spouse or your dependents keep other coverage in addition to this coverage? (Check all that apply) ☐ None ☐ Medical ☐ Dental ☐ Life ☐ Vision ☐Disability Name of covered person(s) Employer (if applicable) Insurance Company/HMO Name and Address Policy No:_____ ☐ Employee Effective Date:_____ ☐ Employee/Spouse End Date:_____ ☐ Employee/Child(ren) ☐ Employee/Spouse/Child(ren)	Within the last 18 months, did you have health insurance coverage? ☐Yes ☐No If Yes, please complete the following: Name of covered person(s) Employer (if applicable) Insurance Company/HMO Name and Address Policy No:_____ ☐ Employee Effective Date:_____ ☐ Employee/Spouse End Date:_____ ☐ Employee/Child(ren) ☐ Employee/Spouse/Child(ren)

Reason for Enrollment/Change:

Name of Affected Party Date of Event

☐ New Hire ☐ Late Enrollee ☐ Special Enrollee ☐ Loss of Coverage ☐ Marriage ☐ Birth/Adoption ☐ Death ☐ Divorce

☐ Employment Termination ☐ COBRA ☐ Cancel Coverage (reason)

☐ Other:

DESIGNATED BENEFICIARIES

Group Term Life and/or Voluntary Term Life Beneficiary Designation
(NOTE: The same beneficiary will be used for both Group Term Life and Voluntary Term Life. If you wish to name different beneficiaries for each coverage, please ask your employer for a beneficiary change form to complete in addition to the information shown below).
All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.

Primary Beneficiaries:

Name and Address	*Percentage*	*Relationship*	*Social Security #*

Contingent Beneficiaries:

Name and Address	*Percentage*	*Relationship*	*Social Security #*

The right to make future changes is reserved. If two or more beneficiaries are named, the proceeds shall be paid to the named beneficiaries, or to the survivor, or survivors, in equal shares, unless specified otherwise.

If any beneficiary is designated as a trustee, it is understood and agreed that the Plan shall not be a party to, nor bound by, the conditions of any trust, and payment of the net proceeds of said policy on the death of the insured to the then-designated beneficiary shall be a complete discharge as to the Plan.

If you have designated a minor child(ren) as your beneficiary, you must complete the Uniform Transfers to Minors Act Form.

UNI_APP2 Agent No:_____ Employee Name

HEALTH INFORMATION QUESTIONS

Please answer each question fully and accurately. You should not disclose genetic information (including family history). Incomplete answers could delay processing.

SECTION 1

Please provide the health history of you and any person named in this application who has been diagnosed or treated in the last **10 years** by placing an "X" in the following boxes. **Please further explain your selections in Section 3 - Health Statement Table**.

☐ 1. AIDS/HIV	☐ 12. Digestive/Gastrointestinal Disorder	☐ 22. Liver (cirrhosis, hepatitis B, C, D or E)
☐ 2. Allergy/Asthma	☐ 13. Drug or Alcohol Abuse	☐ 23. Mental or Nervous Disorder
☐ 3. Arthritis	☐ 14. Eating Disorder	☐ 24. Migraine Headaches
☐ 4. Bladder/Urinary Disorder	☐ 15. Endocrine/Pancreatic Disorder	☐ 25. Neck, Back or Spine Disorder
☐ 5. Blood, Bleeding or Clotting Disorder	☐ 16. Eye, Ear, Nose or Throat Disorder (excluding glasses)	☐ 26. Organ Transplant
☐ 6. Bone/Joint/Muscular Disorder		☐ 27. Respiratory/Lung Disorder
☐ 7. Cancer, Leukemia, or Hodgkin's	☐ 17. Heart/Circulatory Disorder	☐ 28. Skin Disorder
☐ 8. Cyst	☐ 18. High Blood Pressure	☐ 29. Stroke/Nervous System/Brain Disorder
☐ 9. Current Pregnancy: Due Date_____	☐ 19. High Cholesterol	☐ 30. Tumor
☐ 10. Diabetes	☐ 20. Infertility	☐ 31. Tobacco Product Use
☐ 11. Physical Deformity or Defect	☐ 21. Kidney Disorder (dialysis or failure)	☐ 32. Vascular (blood vessel) Disorder

SECTION 2

Please answer yes or no to the following questions. **Please further explain your "Yes" selections in Section 3 - Health Statement Table.**

☐ Yes ☐ No 32. Have you or any person named in this application received inpatient or outpatient services in the last five (5) years (excluding routine tests, physicals or inoculations)?

☐ Yes ☐ No 33. Do you or any person named in this application have tests, treatments, hospitalization or surgery planned or recommended in the future or disabled/restricted from performing self care/activities of daily living?

☐ Yes ☐ No 34. Do you or any person named in this application take any medicine, prescription drugs or require shots/ injections?

☐ Yes ☐ No 35. Do you or any person named in this application have any other medical conditions which have not yet been previously mentioned?

SECTION 3 Health Statement Table

For any of the "X" or "Yes" responses provided in SECTION 1 and 2 questions above, please provide full details in the following table per Question Number (Q#). If you need additional space, please attach another sheet. (An additional sheet must include your signature and the date on it as verification that the information is yours).

Question #	Person Name	Condition	Date Diagnosed	Date Last Treated	**Names** of Medication, **Dosage**, and **Type** of Treatment (e.g., oral, injectable, infusion, inhaled or transdermal)	Is Medication Ongoing?	Degree of Recovery

AUTHORIZATION AND CERTIFICATION

I understand and agree with the following statements with regard to my application for coverage through an insurance carrier:

▪ My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions, but those over the maximum age will be verified when a claim is filed. I have read and understand the Pre-Existing Condition Exclusion and the Special Enrollment Rights and know if I refuse medical coverage, I and my dependents must wait for the next open enrollment unless I become eligible during a Special Enrollment. If I refuse dental coverage, I and my dependents may enroll later, but this will affect the level of benefits. If I refuse life or disability coverage, I may apply later, but I must show proof of good health, and coverage will be subject to approval by the Carrier. If I refuse coverage, I cannot enroll after retirement.

▪ I understand that the coverage applied for will not start until after this application and the appropriate coverage rates are received and accepted by the Carrier and an effective date of coverage is established by the Carrier. I further agree that the Carrier is not liable for a claim before the effective date of coverage and all policy provisions apply. During the first two years coverage for life or disability or medical is in force, false statements, omissions or material misrepresentations can cause changes in that coverage, including cancellation back to the effective date.

▪ Any person who, with intent to defraud or knowingly is facilitating a fraud against an insurer, submits an application or files a claim with false or deceptive statements, may be guilty of insurance fraud.

▪ For life and disability coverages, I authorize any health care provider who has personal information - including physical, mental, drug or alcohol use history - regarding me or a dependent, to give such data to the Life or Disability Carrier agents and employees of the Life or Disability Carrier and I authorize the Life or Disability Carrier to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by the Life or Disability Carrier for determining eligibility for life and disability coverage. Information will not be used for any purposes prohibited by law.

▪ I also understand collection of social security numbers for myself and my dependents will be used by the Carrier only as allowed by law.

▪ For life coverage, I understand that as the employee, the insurance I and my dependents have applied for will begin on the effective date of coverage, provided I am at work on that date. If I am not actively at work on such date - subject to the terms of the group policy - coverage may not go into effect until after my return to work. Furthermore, I understand that no insurance may become effective for any member of my family while he/she is in a period of limited activity.

▪ For medical coverage, I authorize pharmacy benefit managers, "health care providers," including, but not limited to, surgeons, physicians, psychologists, nurses, social workers, health care facilities and other entities covered under the HIPAA Privacy Rule and their agents and employees, to release and disclose my personal health information, including, but not limited to, all health and mental records, including those records protected by Federal or State law relating to the diagnosis or treatment of AIDS or AIDS-related complex, Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental health and substance abuse, the use of alcohol, drugs and tobacco, and the past, present or future treatments or conditions for myself or for my dependents eligible for health care coverage to the Carrier, its agents and employees, for purposes of underwriting my application for coverage, and making eligibility, premium rating and enrollment decisions relating to any coverage I have, have applied for, or may in the future apply for with the Carrier or other entities covered under the HIPAA Privacy Rule. I further understand that the personal health information described above may be disclosed to and/or received by

persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws. This authorization shall remain in force two years following the date of my signature. I may revoke this authorization in writing at any time by sending the request for revocation to the Carrier. I understand that a revocation is not effective until received by the Carrier and that any revocation is not effective to the extent the Carrier or Providers have relied on the protected health information disclosed to them. This Authorization and Certification does not authorize the redisclosure of medical information except as otherwise stated herein. Federal and State regulations do not allow further disclosure of mental health, substance abuse and AIDS/HIV related information. The Carrier maintains the confidentiality of <u>all</u> information received and it will not be any person or facility unless you apply for life and/or disability coverage underwritten by the Life or Disability Carrier in which case the application, <u>without</u> any further health records or Attending Physician Statements (APS) received, will be released to the Life or Disability Carrier. I understand that if I refuse this authorization, the Carrier may not make an eligibility determination, and I will not be considered for coverage with the Carrier.

I hereby authorize the following Carriers, their reinsurers and their legal representatives to receive, use and disclose my, my spouse and my dependent child(ren)'s Protected Health Information for the purposes of insurance coverage. I authorize the Carriers to disclose my, my spouse and my dependent child(ren)'s Protected Health Information between themselves, to reinsuring companies, to the plan administrator or plan sponsor (if other than the employer), insurance intermediaries or other persons or organizations performing business or legal services in connection with the purpose of insurance coverage: *(Either you or your broker must list all Carriers that are to receive this application for insurance).*

Carrier: Harrington Health

Carrier: Coventry

Carrier BCBSNE

Carrier Starmark

Carrier Allied National

Carrier Time Insurance

Carrier United Health Care

Carrier Principal

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I further certify that, after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that the Carrier will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, the Carrier will be entitled to declare any contract or coverage issued pursuant to this application void and to refuse allowance on benefits to any person thereunder, which means that any claims incurred will become my liability. If the group policy does not require my contribution, I understand that I cannot decline any coverage unless the policy indicates otherwise. If the group policy requires my contribution, I authorize my employer to deduct from my pay. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from the Carrier.

Printed Name _____

UNI_APP2 **Signature** _____ **Date Signed** _____