



10825 Financial Centre Parkway
Suite 400
Little Rock, AR 72211

EMPLOYEE APPLICATION (2-50)

Please check the appropriate boxes and fill in blanks below in ink.

Is the Employee waiving coverage in the plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete Sections 1, 3 & 7 only.			QualChoice Use Only		
<input type="checkbox"/> New Enrollee <input type="checkbox"/> Loss of Other Coverage		<input type="checkbox"/> Add a Family Member: <input type="checkbox"/> Newborn – Date of Birth: _____ <input type="checkbox"/> Marriage – Marriage Date: _____ (Submit copy of marriage certificate.)		Subscriber ID:	
Date of Full-Time Employment		COBRA/State Continuation Effective Date		COBRA/State Continuation Termination Date	
Mo	Day	Year	Mo	Day	Year
Reason for COBRA/State Continuation:					

SECTION 1. EMPLOYEE INFORMATION

First Name		Middle Name		Last Name		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Home Address				City		State	
Home Phone No.		Work Phone No.		Employer		Subscriber E-Mail Address:	
Coverage Desired: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse		<input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> Employee & Family		Employment Status: <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried		Hours Worked Weekly _____ <input type="checkbox"/> Other	

Are you a current, active employee? Yes No If No, reason:

SECTION 2. ENROLLEE INFORMATION (Complete this section on all members to be covered.)

Social Security Number	First Name	M I	Last Name	Zip Code of Residence	Birth Date Mo/Day/Yr	Sex M Or F	Height/Weight	Primary Care Physician	PCP Number (9-digit)
Employee _____-_____-_____							Ht. _____ Wt. _____		
Spouse _____-_____-_____							Ht. _____ Wt. _____		
Child - <input type="checkbox"/> Nat. <input type="checkbox"/> Step <input type="checkbox"/> Adop. _____-_____-_____							Ht. _____ Wt. _____		
Child - <input type="checkbox"/> Nat. <input type="checkbox"/> Step <input type="checkbox"/> Adop. _____-_____-_____							Ht. _____ Wt. _____		
Child - <input type="checkbox"/> Nat. <input type="checkbox"/> Step <input type="checkbox"/> Adop. _____-_____-_____							Ht. _____ Wt. _____		
Child - <input type="checkbox"/> Nat. <input type="checkbox"/> Step <input type="checkbox"/> Adop. _____-_____-_____							Ht. _____ Wt. _____		

College Student's Name	Name of Accredited School/College at which dependent is a full-time student	City	State

Are any dependents listed above disabled? Yes No If Yes, list dependent(s) name(s):

SECTION 3. WAIVER OF ENROLLMENT/SPECIAL ENROLLMENT RIGHTS

Please list individual(s), including yourself, if applicable, for whom you did not apply for coverage. Indicate whether the named individual(s) have coverage with another group plan or other insurance:				For Office Use Only	
Name	Dependency Relationship	Other Coverage	Name of Health Insurance Co.	Group Number:	
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		<input type="checkbox"/> Yes <input type="checkbox"/> No		Sub Group Number:	
		<input type="checkbox"/> Yes <input type="checkbox"/> No		Benefit Plan:	

If you are married or have dependent children and are NOT enrolling as a family, please indicate yourself or any dependents (including your spouse) for whom you are waiving coverage. Other:

SECTION 3. WAIVER OF ENROLLMENT/SPECIAL ENROLLMENT RIGHTS (continued)

I hereby certify that: (1) I have been given the opportunity to apply for the coverage made available through my employer under the applicable policy. The coverages and the policy have been thoroughly explained to me, and I decline to apply for coverage for myself and/or my dependent(s) as listed above; and (2) I understand that if I refuse to apply now and I apply for coverage at a later date, I may be enrolled as a Late Enrollee or my request may be deferred until the annual open enrollment period.

Special Enrollment Period. If you are declining enrollment for yourself or your dependent(s) (including your spouse) because of other insurance coverage, in order to enroll yourself and/or your dependents in your employer’s plan in the future without being considered a Late Enrollee you must: (1) Indicate on this application form that the reason you or your dependent(s) are declining coverage now is because you or your dependent(s) have coverage under another group health plan; and (2) Submit a Group Enrollment Form to enroll yourself or your dependent(s) within 30 days after coverage ends under the other group health plan. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse and/or your new dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

SECTION 4. OTHER MEDICAL INSURANCE

(This section must be completed to process your enrollment application.)

Will you, your spouse or dependents be continuing any other health insurance coverage, including Medicare? Yes No

If you answered Yes, complete Part 1 and/or Part 2 as applicable – (Use additional paper if necessary)

Part 1: Medicare: Reason for Medicare coverage: Over 65 Disabled Kidney Disease

Medicare Beneficiary Name:

Medicare Health Identification Contract (HIC) Number:

Relationship of Beneficiary to Policyholder:

Type of Medicare Coverage (Check all that apply)

Medicare Part A – Effective Date: Medicare Part B – Effective Date: Medicare Part D – Effective Date:

Part 2: If continuing coverage is other than Medicare, complete the following – (if covered by more than one insurance plan, use additional paper)

Name of Insurer	Address	Phone
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Policyholder Name	Date of Birth	Member ID #
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List the following information for all members covered by this policy (indicate those not residing in your household with a check ✓ mark)

First Name	Last Name	Relationship	✓	Effective Date of Coverage

For members listed above, are you responsible for providing primary health insurance coverage? Yes No If No, please name responsible party(ies):

SECTION 5. CREDITABLE COVERAGE INFORMATION

If the coverage for which you are making application contains a pre-existing condition limitation period, you may be able to offset part or all of such period by attaching a Certificate of Creditable Coverage to this application. Federal and state law require your prior health plan(s) or health insurance company(ies) to provide you such Certificate(s) of Creditable Coverage upon request. If, for some reason you are unable to attach such a Certificate of Creditable Coverage, please include whatever documents you have (i.e., explanation of benefits forms, correspondence from your former health plan or health insurer, former identification card, or benefit certificate) which will assist us to corroborate your prior creditable coverage.

Do you or any dependent listed in this application currently have or have you (they) had any health coverage within the past 63 days?

Yes No If Yes, please provide the coverage history for the past 18 months in the spaces below. If No, you and your covered dependents will be subject to pre-existing conditions limitations.

Name of Persons Covered	Name, Address, Phone No. & Policy No. of Prior Health Insurance Co.	Effective Date	Termination Date	Reason for Termination

SECTION 6. MEDICAL QUESTIONNAIRE

All of the following questions must be answered in ink in the employee's own handwriting for each person applying for coverage. Use a separate sheet, if necessary; sign, date, and attach to the questionnaire. **YOUR COVERAGE CANNOT BE DECLINED BASED ON HEALTH CONDITIONS.** However, **FAILURE TO REVEAL ALL MEDICAL INFORMATION WHETHER INTENTIONAL OR UNINTENTIONAL MAY RESULT IN TERMINATION OR RESCISSION OF COVERAGE.**

1. Has any person to be insured ever been declined, surcharged, rescinded or restricted for the issuance of life, health or accident insurance? Yes No If YES, Member: _____ Reason: _____

2. Has any person to be insured ever had, been diagnosed or been advised to have treatment or care for any of the following conditions, disorders or problems? Check the appropriate box(es) below and explain in Additional Medical Information.

- | | | |
|---|--|--|
| Y <input type="checkbox"/> N <input type="checkbox"/> | Y <input type="checkbox"/> N <input type="checkbox"/> | Y <input type="checkbox"/> N <input type="checkbox"/> |
| <input type="checkbox"/> <input type="checkbox"/> 3. Heart Condition | <input type="checkbox"/> <input type="checkbox"/> 18. Liver Disorder/Problem | <input type="checkbox"/> <input type="checkbox"/> 27. Stroke or Seizure |
| <input type="checkbox"/> <input type="checkbox"/> 4. Circulatory/Blood Disorder | <input type="checkbox"/> <input type="checkbox"/> 19. Digestive Disorder/Problem | # of episodes: _____ |
| <input type="checkbox"/> <input type="checkbox"/> 5. Pancreatic Disorder | <input type="checkbox"/> <input type="checkbox"/> 20. Kidney Disorder/Problem | <input type="checkbox"/> <input type="checkbox"/> 28. Drug Abuse/Dependency |
| <input type="checkbox"/> <input type="checkbox"/> 6. Lung Disorder/Problem | <input type="checkbox"/> <input type="checkbox"/> 21. Bladder/Prostate Disorder | Name of Drug: _____ |
| <input type="checkbox"/> <input type="checkbox"/> 7. COPD or Asthma | <input type="checkbox"/> <input type="checkbox"/> 22. Tobacco Use | <input type="checkbox"/> <input type="checkbox"/> 29. Cancer |
| <input type="checkbox"/> <input type="checkbox"/> 8. Brain Disorder/Injury | <input type="checkbox"/> <input type="checkbox"/> 23. Hospital Visits | Type: _____ |
| <input type="checkbox"/> <input type="checkbox"/> 9. Mental Disorder/Problem | <input type="checkbox"/> <input type="checkbox"/> 24. Surgery _____ | <input type="checkbox"/> <input type="checkbox"/> 30. Arthritis |
| <input type="checkbox"/> <input type="checkbox"/> 10. Depression | <input type="checkbox"/> <input type="checkbox"/> 25. High Blood Pressure | Type: _____ |
| <input type="checkbox"/> <input type="checkbox"/> 11. Anxiety | Last 2 readings with date: | <input type="checkbox"/> <input type="checkbox"/> 31. Hepatitis |
| <input type="checkbox"/> <input type="checkbox"/> 12. Alcohol Abuse | _____/____/____ Date _____; ____/____/____ Date _____ | Type: _____ |
| <input type="checkbox"/> <input type="checkbox"/> 13. Cyst or Tumor | <input type="checkbox"/> <input type="checkbox"/> 26. Diabetes or High Blood Sugar | <input type="checkbox"/> <input type="checkbox"/> 32. Currently Pregnant |
| <input type="checkbox"/> <input type="checkbox"/> 14. AIDS or HIV positive | Last 2 blood sugar readings with date: | Due Date: _____ |
| <input type="checkbox"/> <input type="checkbox"/> 15. Immune Disorder | ____ Date _____; ____ Date _____ | <input type="checkbox"/> <input type="checkbox"/> 33. Any Condition not Listed Above |
| <input type="checkbox"/> <input type="checkbox"/> 16. Recurrent Pain | Last hemoglobin A1C determination: | _____ |
| <input type="checkbox"/> <input type="checkbox"/> 17. Reproductive Disorder | Date: _____ Result: _____ | |

34. Has any person to be insured ever been to see, or been advised to see a surgeon, chiropractor, counselor, psychiatrist, social worker, pain specialist, physical therapist, speech therapist, rehabilitation therapist, occupational therapist, oncologist, endocrinologist or other health care provider within the past 10 years? Yes No (Circle each provider and give details in the Additional Medical Information Section below.)

ADDITIONAL MEDICAL INFORMATION List below full details to questions answered "Yes". (Use separate sheet if necessary. Sign, date and attach to this application.)

Question Number	Person Treated	Condition & Type of Treatment	Date Occurred	Last Date of Treatment	Current Status	Complete Name and Address of Physician

35. Has any person to be insured been prescribed or taken any prescription medication for more than total of 30 days in the past 2 years? Yes No If "Yes" list full details below. (Use separate sheet if necessary. Sign, date and attach to this Application.)

PRESCRIPTION INFORMATION

Person Treated	Name of Drug	Dosage	Condition or Illness	Start Date	Stop Date	Complete Name and Address of Physician

36. In the past 2 years, has any person to be insured discontinued or failed to take medication prescribed by a physician? Yes No If Yes, describe in space below. (Use separate sheet if necessary. Sign, date and attach to this Application.)

