

This enrollment application contains two parts: the Disclosures Section and the Enrollment Information Section. **Read the Disclosures Section** carefully. **Detach the Disclosures page** and save it for future reference. **Complete the attached enrollment application.** Answer everything in this application that applies to you. Please **sign and date** before **returning the form to your plan administrator.**

Pre-Existing Condition Exclusion Period – Guidelines for Section 5

What is a pre-existing condition? A pre-existing condition is any physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended by or received from a licensed provider during the six months preceding the effective date of coverage.

The pre-existing conditions exclusion period does not apply to: Newborn babies; Newly adopted children; Pregnancy; Genetic information without a diagnosis of a condition related to such information; Employees who re-enroll after a layoff if they returned to work within six months, to the extent the exclusion period was satisfied before the layoff (exclusion period does apply to their family members, however); or Employees who re-enroll after leave under the Family Medical Leave Act, and their previously enrolled dependents, to the extent the exclusion period was satisfied before the leave.

How long is coverage for pre-existing conditions excluded? The plan excludes coverage for pre-existing conditions for twelve months. The twelve-month exclusion period begins on your effective date of coverage.

If I had prior health coverage, will my pre-existing condition exclusion period be shortened or eliminated? You can receive credit if you had qualifying health coverage before enrolling in this plan and there was no more than a 63-day gap between your last day of coverage under the prior plan and your first day of coverage (or the first day of your employer's eligibility waiting/probationary period) under this plan. Your prior coverage must have been qualifying existing coverage. Dependents meeting these qualifications will qualify for credit.

It is your responsibility to show us you had creditable coverage in writing. If you qualify for credit, we will count every day of coverage under your prior plan toward this plan's exclusion period for pre-existing conditions.

How can I prove my prior creditable coverage? You can show evidence by sending us a Certificate of Creditable Coverage from your previous health plan. All health plans, insurance companies, and HMOs should provide these certificates on request, and most issue these automatically when coverage ends. The certificate shows how long you were covered under your previous plan and when coverage ended.

If you do not have a certificate of prior coverage, contact your prior insurance company or plan sponsor (such as your former employer, if a group health plan). If you are unable to obtain a certificate, contact the PacificSource Membership Services Department to assist you.

Example of how your plan's pre-existing exclusion period rules work. Mike worked at Oldco, and was covered under Oldco's group health plan for five months. He did not have any health coverage before his Oldco group plan. Mike quit his job at Oldco and did not elect any continuation coverage. Exactly 60 days after quitting, Mike was hired full time at Newco. Newco has a PacificSource group health plan. Mike enrolled in Newco's group plan as soon as he satisfied Newco's eligibility waiting/probationary period.

Mike will receive five months of prior coverage credit for the Oldco coverage because the gap was less than 63 days. His pre-existing conditions exclusion period is reduced to seven months, which begins on his enrollment date (after he satisfies Newco's eligibility waiting/probationary period). Mike's pre-existing conditions look back period is the six months ending on his hire date.

Health Statement Section – Guidelines for Section 7

The Health Statement section must be filled out completely and accurately for each person listed on the application. The insurer may, at its discretion, request supplemental information from the applicant, any family member listed on this application, or any healthcare provider. If the insurer discovers any intentional misrepresentation, omission, or concealment of fact in obtaining coverage that was or would have been material to the insurer's acceptance of a risk, extension of coverage, provision of benefits, or payment of any claim, the insurer may take action against the applicant's employer, including but not limited to increasing premiums. If you learn at any time before approval of coverage by the Insurer that any answer on this application is incomplete, **you must advise the Insurer.**

Special Enrollment Rights – Employee and Eligible Family Members

This group health plan offered by your employer contains provisions that, in certain situations, may allow you or your eligible family members to enroll in the plan later if you decline enrollment when first eligible. If you or your family members decline coverage, you and your family members may enroll in the plan later if you qualify under Rule #1 or #2 below and a "Waiver of Coverage" form was submitted to PacificSource during your initial enrollment period or at the time you disenrolled in the group plan. **If you choose to decline coverage, you must complete a Waiver of Health Insurance Coverage form instead of this application.**

Rule #1 - If you declined enrollment because you had other qualifying health insurance coverage, you may enroll in this plan later if the other coverage ends involuntarily. This also applies to dependents that involuntarily lose other coverage. To enroll, request enrollment and pay required premium within 31 days of losing other coverage. Coverage begins on the first day of the month after other coverage ends.

"Involuntarily" means coverage ended because COBRA was exhausted, employment terminated, work hours were reduced below the employer's minimum requirement, other insurance was discontinued or the maximum lifetime benefit of other plan was exhausted, the employer's premium contributions toward the other insurance plan ended, or because of death of a spouse, divorce, or legal separation.

Rule #2 – If you acquire new dependents due to marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or your new dependents if you request enrollment within 60 days of the marriage, adoption, or placement for adoption, or in the case of a newborn child, within 120 days of birth (a newborn child, including an adopted child placed with you within 60 days of birth, is automatically covered for the first 60 days of life).

SMALL GROUP ENROLLMENT APPLICATION ID



251 East Front Street, Suite 203
Boise, Idaho 83702-7312
(208) 342-3709 or (888) 492-2875
Membership Fax (541) 225-3642
Marketing Fax (541) 485-0915
www.pacificsource.com

Please type or print legibly in black or blue ink. Complete all applicable sections.

Section 1 – Employer Information

Employer/Group Name		Group Policy No. G
Employee Date of Full Time Hire	Number of Hours Worked Per Week	Enrollment Date

Section 2 – Employee Information

Employee Last Name	First Name	M.I.	Social Security Number							
						-				
Address			Home Phone No.							
City		State	Zip code	E-Mail Address						
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single		Job Title or Occupation						

Enrollment

Type of enrollment: New Applicant–Active Employee New Applicant–COBRA Continuation Adding dependents
 Enrollment Due To: New Hire Marriage Birth Adoption Court Order Involuntary loss of other coverage
 Date Qualifying Event Occurred: _____/_____/_____

Section 3 – Family Information

Complete for yourself and each family member you wish to enroll. If this application is for dental coverage only, the policy will provide dental benefits only. Please review your Dental Member Handbook carefully.

Name	Social Security Number	Gender	Birth Date	Coverage	Height	Weight
Employee				<input type="checkbox"/> Medical <input type="checkbox"/> Dental		
Spouse				<input type="checkbox"/> Medical <input type="checkbox"/> Dental		
Child				<input type="checkbox"/> Medical <input type="checkbox"/> Dental		
Child				<input type="checkbox"/> Medical <input type="checkbox"/> Dental		
Child				<input type="checkbox"/> Medical <input type="checkbox"/> Dental		
Child				<input type="checkbox"/> Medical <input type="checkbox"/> Dental		
Child				<input type="checkbox"/> Medical <input type="checkbox"/> Dental		
Child				<input type="checkbox"/> Medical <input type="checkbox"/> Dental		

Students – Name of dependents over age 20 listed above who are full time students and the school they attend:

Section 4 – Child Custody Information

If any of the children you are enrolling above are from a previous marriage, complete this section.

Child's Name	Whose Child	Custodial Parent Name	Custodial Parent Address	Custodial Phone Number	If Court Order, Name Responsible for Insurance
	<input type="checkbox"/> Yours <input type="checkbox"/> Spouse				
	<input type="checkbox"/> Yours <input type="checkbox"/> Spouse				

Para asistirle en español, por favor llame al numero (800) 624-6052, ext. 1009, de Lunes a Viernes, 8:00 a.m. asta 5:00 p.m.

Section 5 – Prior and/or Current Coverage

Complete the following for any person listed on this application that has **other current or prior coverage**.

Please attach proof of prior coverage to reduce your medical pre-existing condition exclusion period (see Disclosure for details).

Names	Insurer or Carrier Name	Insurer Phone Number	Policy or ID Number	Type of Coverage	Will Current Policy Continue?
				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Retiree	<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Retiree	<input type="checkbox"/> No <input type="checkbox"/> Yes

If married: Is your spouse employed? No Yes Self employed

Medicare Information

Name of Insured	Type of Coverage	Original Effective Date
	<input type="checkbox"/> Part A <input type="checkbox"/> Part B	

Section 6 – Disability

Are you or any of your dependents currently disabled? No Yes *If yes, complete the information below.*

Name of Disabled Person:	Nature of Disability:	Date of Disability (month & year):
Physician's Name:	Physician's Address:	Physician's Phone Number:

Section 7 – Health Statement

Each question below applies to **all persons listed** on this application. The questions apply to symptoms, conditions, diseases, illnesses, accidental injuries, or deformities (health conditions) that are **present or occurred in the past**.

All questions must be answered either **“Yes” or “No.”** Answer accurately and **explain any conditions** you answered “Yes” to in the boxes provided below. **Do not leave any question unmarked.**

No agent or any other person can waive these requirements or is authorized to set forth anything less than a complete and accurate response to each of the questions.

If you learn at any time before approval of coverage that any answer on this application is incomplete, you must advise PacificSource.

- | <u>Yes</u> <u>No</u> | <u>Yes</u> <u>No</u> | <u>Yes</u> <u>No</u> |
|---|---|--|
| 1. Are you or family member, whether listed on application, now pregnant <input type="checkbox"/> <input type="checkbox"/>
<i>Due date:</i> _____
<i>Anticipated complications</i> <input type="checkbox"/> <input type="checkbox"/>
<i>Prior or anticipated multiple births</i> <input type="checkbox"/> <input type="checkbox"/> | 14. Breast condition or fibrocystic breast disease <input type="checkbox"/> <input type="checkbox"/>
15. Cancer <input type="checkbox"/> <input type="checkbox"/>
<i>If yes, list type:</i> _____ | 30. Injuries, accidents, or broken bones .. <input type="checkbox"/> <input type="checkbox"/>
<i>If yes, pins in place</i> <input type="checkbox"/> <input type="checkbox"/>
31. Liver condition, cirrhosis, or hepatitis . <input type="checkbox"/> <input type="checkbox"/>
<i>If yes, list type:</i> _____ |
| 2. Positive test for HIV - Human Immunodeficiency Virus Infection . <input type="checkbox"/> <input type="checkbox"/> | 16. Colon, bowel, or intestinal condition <input type="checkbox"/> <input type="checkbox"/> | 32. Lung condition or emphysema <input type="checkbox"/> <input type="checkbox"/> |
| 3. Acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC) <input type="checkbox"/> <input type="checkbox"/> | 17. Depression..... <input type="checkbox"/> <input type="checkbox"/> | 33. Lupus..... <input type="checkbox"/> <input type="checkbox"/> |
| 4. Alcoholism, drinking problem, drug abuse, or convicted of DUI/DWI..... <input type="checkbox"/> <input type="checkbox"/> | 18. Diabetes..... <input type="checkbox"/> <input type="checkbox"/> | 34. Melanoma..... <input type="checkbox"/> <input type="checkbox"/> |
| 5. Allergies or Hay Fever..... <input type="checkbox"/> <input type="checkbox"/> | 19. Disorder of the female reproductive organs or infertility <input type="checkbox"/> <input type="checkbox"/> | 35. Mental or nervous condition..... <input type="checkbox"/> <input type="checkbox"/> |
| 6. Anemia or blood condition..... <input type="checkbox"/> <input type="checkbox"/> | 20. Disorder of the male reproductive organs, including the prostate or infertility ... <input type="checkbox"/> <input type="checkbox"/> | 36. Mental retardation <input type="checkbox"/> <input type="checkbox"/> |
| 7. Arthritis or rheumatism <input type="checkbox"/> <input type="checkbox"/>
<i>Osteoarthritis</i> <input type="checkbox"/> <i>Rheumatoid</i> <input type="checkbox"/> | 21. Dizziness or headaches <input type="checkbox"/> <input type="checkbox"/> | 37. Neurological condition..... <input type="checkbox"/> <input type="checkbox"/> |
| 8. Asthma or chronic bronchitis..... <input type="checkbox"/> <input type="checkbox"/> | 22. Epilepsy or seizure condition..... <input type="checkbox"/> <input type="checkbox"/> | 38. Phlebitis or blood clot..... <input type="checkbox"/> <input type="checkbox"/> |
| 9. Attempted suicide..... <input type="checkbox"/> <input type="checkbox"/> | 23. Eye, ear, nose, or throat condition <input type="checkbox"/> <input type="checkbox"/> | 39. Polio <input type="checkbox"/> <input type="checkbox"/> |
| 10. Back or joint condition <input type="checkbox"/> <input type="checkbox"/>
<i>If yes, pins or implants in place</i> .. <input type="checkbox"/> <input type="checkbox"/> | 24. Gallstone or gall bladder condition <input type="checkbox"/> <input type="checkbox"/> | 40. Sinus condition <input type="checkbox"/> <input type="checkbox"/> |
| 11. Bladder or kidney condition..... <input type="checkbox"/> <input type="checkbox"/> | 25. Heart or cardiovascular condition .. <input type="checkbox"/> <input type="checkbox"/> | 41. Stomach condition or ulcer <input type="checkbox"/> <input type="checkbox"/> |
| 12. Bodily deformity or congenital disease/defect <input type="checkbox"/> <input type="checkbox"/> | 26. Hemorrhoids or rectal condition.... <input type="checkbox"/> <input type="checkbox"/> | 42. Stroke or paralysis <input type="checkbox"/> <input type="checkbox"/> |
| 13. Bone infection <input type="checkbox"/> <input type="checkbox"/> | 27. Hernia or rupture..... <input type="checkbox"/> <input type="checkbox"/> | 43. Thyroid or pituitary condition <input type="checkbox"/> <input type="checkbox"/> |
| | 28. High blood pressure <input type="checkbox"/> <input type="checkbox"/>
<i>If yes, last reading & date:</i> _____ | 44. Tuberculosis..... <input type="checkbox"/> <input type="checkbox"/> |
| | 29. High cholesterol <input type="checkbox"/> <input type="checkbox"/>
<i>If yes, last reading & date:</i> _____ | 45. Tumor, growth, or cyst <input type="checkbox"/> <input type="checkbox"/> |
| | | 46. Ulcerative colitis or Crohn's Disease . <input type="checkbox"/> <input type="checkbox"/> |
| | | 47. Varicose veins..... <input type="checkbox"/> <input type="checkbox"/> |

If you answered “yes” to any question above, please explain on the next page.

If you answered "yes" to any question on the previous page, please explain below. Use extra paper if necessary.

Item No.	Patient's Name	Diagnosis/Condition Type of Treatment	Physician's Name, City, and State	Date of Illness	Date of Last Visit	Recovery Complete	Medication	Still Taking
						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

48. Do you have a family doctor? Yes No If yes, physician name: _____

49. Has any person listed on this application or resides in your household used tobacco during the past 12 months? Yes No

50. Suffered from or now suffer from any chronic or recurring ailment, illness, or other departures from good health, regardless of whether a physician or other health care provider was contacted? Yes No If "Yes," list name and details: _____

51. Has surgery, diagnostic testing, medical treatment, or follow-up visit been advised (but not yet performed) for any person listed on this application? Yes No If "Yes," list name and details: _____

52. Has any named person incurred medical expenses or claims exceeding \$10,000 in the past 24 months? Yes No
If "Yes," list name and details: _____

53. Are you or any family members listed on this application covered on Medicare or have received Social Security Disability or Workers' Compensation payments or are now eligible to receive such payments? Yes No
If "Yes," list name and details: _____

54. Has any insurer refused, restricted (including waiver or condition), or rated any health coverage for you or any dependents listed on this application? Yes No If "Yes," list details: _____

Section 8 – Health Information Acknowledgement and Declaration

I acknowledge and understand that my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on this enrollment form) from time to time for the purpose of facilitating health care treatment, payment, or for business operations necessary to administer health care benefits; or as required by law. Health information requested or disclosed may be related to treatment or services performed by: a physician, dentist, pharmacist, or other physical or behavioral healthcare practitioner; a clinic, hospital, long term care, or other medical facility; any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or an insurer or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). A separate authorization will be used for to obtain information regarding psychotherapy notes. I also understand that this authorization is needed for the purpose of gathering information to make eligibility or underwriting and risk rating determinations.

As proof of status of employment, I authorize my employer to release to PacificSource appropriate documents, including but not limited to W-2 Wage and Tax Statements and other wage and tax summaries or forms.

Unless revoked earlier, this authorization will be valid for sixty (60) days after the date it is signed. I understand that I can revoke this authorization at any time by giving written notices to PacificSource. I understand that this application will become part of the contract between PacificSource and my employer. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation.

I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may not be protected by federal rules governing privacy and confidentiality.

I have reviewed all answers and, regardless of whether a producer or other person has completed the answers for me, I affirm that the answers on this application are true and complete. PacificSource may terminate or rescind an employer's group coverage for any revocation or misrepresentation or omission of fact that would have been material in acceptance of a risk, extension of coverage, provision of benefits, or payment of any claim.

Employee Signature

Date

Spouse Signature

Date

