

**IDAHO 51-99
MID-SIZE GROUP
ENROLLMENT
APPLICATION**



408 E Parkcenter Blvd, Suite 100
Boise, Idaho 83706
208.342.3709 or 888.492.2875
Membership Fax 208.433.4600
Marketing Fax 208.344.4262
Pacifsource.com

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

Group Policy No.	Subgroup No.	Class No / Classification.	Name of Medical Plan
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Section 1 – Employer Information

Employer/Group Name	Effective Date month_____ day_____ year_____
Date of Full Time Hire (required) month_____ day_____ year_____	Number of Hours Work Per Week
Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Other_____	

Section 2 – Employee Information

Employee Last Name	First Name	M.I.
Mailing Address		
City	State	Zip code
Home Phone No.	E-Mail Address	Job Title
Date of Birth month_____ day_____ year_____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other_____

Type: New Applicant–Employee Add dependents COBRA–qualifying event_____

Due To: New Hire Marriage Birth Adoption* Court Order* Involuntary loss of other coverage*

Date Qualifying Event Occurred: month_____ day_____ year_____ ***Attach proof of qualifying event**

Section 3 – Employee and Family Members You Wish to Enroll

***If this application is for dental coverage only, the policy will provide dental benefits only.**

****Race/Ethnicity** (choose the code each family member would most closely identify with) : **A**-American Indian/Alaska Native, **B**-Asian, **C**-Black/African American, **D**-Hispanic/Latino, **E**-Native Hawaiian/Other Pacific Islander, **F**-White/Caucasian

Name	Gender	Birth Date	Social Security Number (Required–refer to disclosure)	*Coverage	**Race / Ethnicity Code
Employee				<input type="checkbox"/> Medical <input type="checkbox"/> Dental	
Spouse				<input type="checkbox"/> Medical <input type="checkbox"/> Dental	
Dependent Child				<input type="checkbox"/> Medical <input type="checkbox"/> Dental	
Dependent Child				<input type="checkbox"/> Medical <input type="checkbox"/> Dental	
Dependent Child				<input type="checkbox"/> Medical <input type="checkbox"/> Dental	
Dependent Child				<input type="checkbox"/> Medical <input type="checkbox"/> Dental	
Dependent Child				<input type="checkbox"/> Medical <input type="checkbox"/> Dental	
Dependent Child				<input type="checkbox"/> Medical <input type="checkbox"/> Dental	

If you or your spouse are a court-ordered guardian of any dependent listed above, identify and provide proof:

Name(s):_____ Type: Grandchild Niece/Nephew Sibling Other_____

Primary language spoken in household: English Español Other:_____

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

Section 4 – Prior and/or Current Coverage

Current or Prior Coverage Information – Do you or any person listed on this application have or have had health insurance in the last 12 months? No Yes If yes, complete the following **and** attach proof with dates of coverage.

Name	Insurance Carrier	Date of coverage	Will Coverage Continue?	Type of Coverage
	Carrier Name: Policy No.: Phone No.:	Begin: End:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree
	Carrier Name: Policy No.: Phone No.:	Begin: End:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree

Married – Is your spouse employed? No Yes If yes, self employed? No Yes

Medicare – If you or any person on this application have Medicare, is coverage? Part A Part B Part D

Name	Original Effective Date	Medicare HICN	Medicare No. (include alpha suffix)	Reason for Entitlement
				<input type="checkbox"/> Age <input type="checkbox"/> ESRD <input type="checkbox"/> Disability <input type="checkbox"/> Dual Entitlement

Section 5 – Child Custody Information

If you are enrolling children of a previous relationship, you must complete this section.

Child's Name	Whose Child	Joint Custody	Custodial Parent Name	Custodial Parent Address	Custodial Parent Phone No.	If Court Order, Name Responsible for Insurance
	<input type="checkbox"/> Yours <input type="checkbox"/> Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yours <input type="checkbox"/> Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Section 6 – 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 condition) that are **present or occurred in the past**. Do **not leave any question unmarked**. If you learn at any time before approval of coverage that any answer is incomplete, you must advise PacificSource.

- Have you or any family member enrolling ever been advised to have a surgical operation(s) that you or any family member have not yet had? Yes No
- Do you or any family member enrolling suffer from chronic or recurring ailments, illnesses or other departures from good health, regardless of whether a physician or health care professional has been consulted? Yes No
- During the past 12 months, have you or any family member enrolling received a prescription or taken any prescribed medication? Yes No
- Are you, or any family member, whether or not listed on this application, now pregnant? Yes No
If pregnant, due date: _____
- Have you or any family member enrolling ever been refused or issued restricted health insurance coverage or been offered a program with a rider attached that restricted or excluded benefits for certain conditions? Yes No
- Have you or any family member enrolling been hospitalized during the last 5 years? Yes No
- Have you or any family member enrolling ever had, been told her or she had, been counseled or treated for any of the following: cancer, heart problem/disorder, immune disorder, renal/kidney disease, skin conditions, strokes, mental or nervous disorders, or respiratory disorders? Yes No
- A. Have you or any member of your family had any of the following conditions: current endometriosis, unoperated cataracts, kidney stones, unoperated gall bladder condition, conditions resulting from low birth weight, TMJ, Lupus, angina, sleep apnea, Multiple Sclerosis? Yes No
B. Have you or any member of your family had any of the following conditions: mental/nervous disorders, angina, respiratory disorders/emphysema/COPD? Yes No
- Have you or any member of your family had any of the following conditions: cancer (non-skin), chronic heart or circulatory disease, congenital heart condition? Yes No
- Have you or any member of your family had any of the following conditions: immune disorder/AIDS/HIV positive, stroke, heart attack, renal/kidney disease/kidney failure, acute heart failure? Yes No
- Within the past two years, have you or any member of your family been treated for back/joint disorder? Yes No
- Has testing or treatment been advised but not yet performed for you or any member of your family? Yes No

If you answered "Yes" to any question on the prior page, please explain below. Additional space on next page if needed.

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
						<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

Section 7 – Disability

If you or any of your dependents are currently disabled, 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 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 to obtain information regarding psychotherapy notes. I 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

Spouse Signature

Date

Date

IDAHO MID-SIZE GROUP ENROLLMENT APPLICATION GUIDELINES AND ADDITIONAL INFORMATION

Social Security Numbers – Guidelines for Section 3

A Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) requires group health plan insurers to report information that the Secretary of the Department of Health and Human Services for purposes of coordination of benefits. To coordinate Medicare payments with other insurance benefits properly, Medicare relies on the collection of both the Social Security Number (or Medicare Health Insurance Claim Numbers) and the Employer Identification Number. Please provide Social Security Numbers for each family member listed.

Pre-Existing Condition Exclusion Period – Guidelines for Section 4

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, and do not apply to members under age 19.

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 6

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.

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, birth, or placement for adoption.

Dental Coverage – Dental and medical late enrollment provisions are different. An employee or dependent that did not enroll within the initial enrollment period may enroll later on the policy's anniversary date. An employee or dependent that enrolled and later discontinued coverage may re-enroll on the anniversary date of the policy following a 24-month waiting period from date coverage was discontinued.