

ICHP 24+ APPLICATION

Group Enrollment Form

(Please Print in Ink with a Ball Point Pen)

Employer _____
 Employee _____ SS# _____ Birthdate _____
 Address, City, State and Zip _____
 Male Female Single Married Widowed Divorced Separated
 Home Phone (____) _____ Work Phone (____) _____ Date Employed Full-time _____
 # of Hours Worked per week for Employer _____ Salary _____ Annual Monthly Biweekly Weekly
 Occupation of Duties _____

Dates of continuous health coverage prior to this plan: ___/___/___ to ___/___/___ (attach certification(s)) Insurer: _____

Do you want medical coverage for yourself? Yes No If "No" to either question, complete TO DECLINE
 Do you want medical coverage for your dependents? Yes No COVERAGE Section below. If dependents are to be covered, list below.

Dependent Name	SS#	Sex	Birth date
Spouse			
Children - List each child with the oldest first. If age 19 or older , list only if a full-time student.			
For any child over 19 and a full-time student, give name of school..			

MEDICAL QUESTION

Within the last 5 years, have you or any dependent been medically diagnosed/treated for any of the following chronic medical conditions or have you been medically advised to undergo surgery or hospitalization?: Yes No
(If "Yes" Please Circle and complete below stating date(s), attending physician(s) and treatment(s). Attach additional sheet if necessary):
 Heart or lung condition; cancer; liver or kidney disease; diabetes; neuromuscular disorder, HIV, AIDS, Aids Related Complex (ARC); or are any of you now: pregnant; disabled.

Name of patient: _____	Name of patient: _____
Date of first treatment: _____	Date of first treatment: _____
Date(s) of following treatment(s): _____	Date(s) of following treatment(s): _____
Degree of recovery: _____	Degree of recovery: _____
Condition treated: _____	Condition treated: _____
Medication and dosage taken: _____	Medication and dosage taken: _____
Date - From: _____ Through _____	Date - From: _____ Through _____

COORDINATION OF BENEFITS

Are you or any of your dependents covered under another employer benefit plan? Yes No
 If "Yes" - Who? _____ Date effective ___/___/___
 Insurance Carrier(s): _____
 Spouse's Employer: _____

• To Request Coverages (Please read and sign below.)

I am requesting the coverage(s) selected above under the group policy(ies) issued by the insurer. I authorize any licensed physician, medical practitioner, hospital, medically related facility, utilization management or peer review organization, or any insurance company institution or person having any records or knowledge of myself, my health, and/or my dependents and their health to give such information to the insurer, its reinsurers or their representatives. A photocopy of this authorization shall be as valid as the original.

Conditions of Enrollment - I represent that all information supplied on this form is true and complete to the best of my knowledge and belief. I acknowledge and agree to the Conditions of Enrollment and the Consumer Notice(s) on the reverse side of this application.

Employer's Initials _____ **Employee's Signature** _____ **Date** ___/___/___

• To Decline Coverages (Please read and sign below.)

I understand that I am eligible for benefits under the group health insurance plan(s) for employees of the employer named above. Benefits under such plan(s) have been explained to me in detail. After careful consideration, I decline coverage(s) not selected above for myself and/or my eligible dependents and waive all claims to benefits under any of the plan(s).

Reason: Election of HMO coverage provided by my employer Coverage through my spouse's employer
 Declined for contributory benefits (employee pays portion of premium) Other reason

I hereby acknowledge the Health Insurance Portability & Accountability Act (HIPAA) Notice on the reverse side of this application.

Employer's Initials _____ **Employee's Signature** _____ **Date** ___/___/___

Consumer Privacy Notice

Information regarding your insurability will be treated as confidential. We or our reinsurers may, however, make a brief report to the Medical Information Bureau (MIB). The MIB is a non-profit membership organization of life insurance companies. It operates an information exchange on behalf of its members. If you apply to another MIB member company for: life or health coverage; or, a claim of benefits, the MIB, upon request will supply such company with the information it may have in its file.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction. This may be done by following the procedures set forth in the Federal Fair Credit Reporting Act.

The address of the MIB's information office is: P.O. Box 105, Essex Station, Boston, Massachusetts 02112. Their telephone number is (617) 426-3660.

We or our reinsurers may also release information in our files to other life insurance companies if you: apply for life or health insurance with them; or, file for a benefit claim.

Federal law required that notice of investigation be given to you if applying for insurance. By applying for insurance with us or our reinsurers, it is understood that an investigative consumer report may be prepared. Information is obtained through personal interviews with your neighbors, friends or others who know you. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional information about the nature and scope of this investigation.

Notices

Any person who knowingly and willfully, for the purpose or attempt of procuring payments of any false or fraudulent claim or other benefit from an insurer: 1) makes or aids in making any false statement or representation or any material fact or thing, in: a) a written statement; b) the filing of a claim; c) the application or enrollment for coverage; or, 2) makes a written false representation as to the death or disability of an insured – commits the crime of insurance fraud. If you decline enrollment for yourself or a dependent because of other health coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided you request enrollment within 30 days after you other coverage ends. 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 and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.