

Employee Enrollment Application

Administered By: Gettysburg Health Administrators, Inc.

404 Baltimore Street, P.O. Box 1060 Gettysburg, PA 17325-1060

- Inter-County Hospitalization/Health Plan
- Harleysville Life Insurance Company
- Delta Dental (2-9 only; for 10+ use SBA forms)

- New Enrollment
- Add Dependent

Name of Employer:

Please complete *each* section of this application in ink.

Shaded Area For Office Use Only	Group #:	Eff. Date:	Processed by:	Date:
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Applicant Information (Employee)					
Your Name (last, first, initial):					Social Security Number: - -
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yy): / /	Date of Full-Time Employment: / /	Earnings: \$ _____ <input type="checkbox"/> Annual <input type="checkbox"/> Weekly <input type="checkbox"/> Hourly	Weekly Hours: _____/per week	Are you working your regular work week with this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No - Reason: <input type="checkbox"/> COBRA <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Other
Home Address (Street or Route):			City, State, Zip Code:		
Phone Number::		Email Address:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated	
Are you covered by Workers' Compensation: <input type="checkbox"/> Yes <input type="checkbox"/> No		Job Title/Duties:		Insurance Class:	

Family Member Information (If you choose not to enroll all your eligible family members, you must complete a waiver form)						
<i>List all family members you wish to enroll, including any child who is under age 26; or who is medically certified as disabled and dependent on parent for support (copy of certification required).</i>						
	Status	Gender	Date of Birth (mm/dd/yy)	Social Security #	Height (ft-in)	Weight (lbs)
Applicant/Employee	SELF					
Family Member's Name (last if different than employee, first, initial)						
	<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			
Family Member's Name (last if different than employee, first, initial)						
	<input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			
Family Member's Name (last if different than employee, first, initial)						
	<input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			
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	<input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			
Family Member's Name (last if different than employee, first, initial)						
	<input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			

404 Baltimore St. • Gettysburg, PA 17325 • (800) 497-4474

Mailing Address: P.O. Box 1060 • Gettysburg, PA 17325

Type of Enrollment

Health Coverage <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child/Children	Dental Coverage <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child/Children	Vision Coverage <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child/Children	Life Coverage <input type="checkbox"/> Self only	STD Coverage <input type="checkbox"/> Self only
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Coordination of Benefits

Do you or any of your family members have other medical and/or dental coverage? YES NO
Coordinating your insurance benefits could reduce the amount you owe a provider.
(Please use extra paper if necessary.)

Other Health Insurance Carrier Plan Name: <input type="checkbox"/> Self _____ <input type="checkbox"/> Spouse _____ <input type="checkbox"/> Child/Children _____	Other Dental Insurance Carrier Plan Name: <input type="checkbox"/> Self _____ <input type="checkbox"/> Spouse _____ <input type="checkbox"/> Child/Children _____
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If any person listed on this application is covered by Medicare, please complete the following:

<u>Name</u> _____	<u>Medicare Beneficiary Number</u> _____	<u>Reason for Medicare Entitlement (age, disability or ESRD)</u> _____
	Part A	Part B
<u>Date of Medicare Entitlement</u> _____	_____	_____
	mm / dd / yy	mm / dd / yy

If you have had other coverage with another carrier within 63 days (excluding any employee's probationary period) of this request, please attach a copy of your **Certificate of Coverage**; this will ensure proper credit for any preexisting conditions, if applicable, which can be obtained from your current or prior carrier.

To Add Dependent Please Provide Qualifying Event Information

Change current enrollment because of the following event:
 Marriage Divorce Birth Involuntary loss of coverage Death
 Court order (copy of court order required)
Other _____

Date event occurred: _____
mm / dd / yy

Disability Information

Are you or any of your dependents currently disabled? YES NO

<u>Name of Disabled Person</u> _____	<u>Nature of Disability</u> _____
<u>Date of Disability</u> _____	<u>Physician's Name</u> _____ <u>Physician's Phone Number</u> _____
	<u>Physician's Address</u> _____

Health Statement (Please answer each question completely and accurately.)

Each medical question set forth below applies to each person you listed on this application for whom you wish to obtain coverage, and they apply to both past and present symptoms, conditions, diseases, illnesses, accidental injuries, or deformities ("health conditions"). Answer each question completely and accurately. Coverage under the master group policy will not commence until the application is approved by the insurer's Underwriting Department. No independent producer, agent, or any other person can waive its requirements or is authorized to set forth anything less than a complete and accurate response to each of the questions. The insurer shall not be bound by any attempted waiver of complete answers to the questions set forth below.

If you learn at any time before the application is approved by the insurer that any answer on this application is incomplete or inaccurate or is no longer complete and accurate, you must advise the insurer.

Answer questions 1 through 42 **YES** or **NO**. Each of the questions must be answered, even if the answer is **NO**. Answer a question **YES** if you or any family member for whom you want to obtain coverage now has, or at any time in the past has had, or has consulted with a physician or other health care provider concerning the health condition or event specified in that question. Do not leave any question unmarked.

MEDICAL HISTORY								
		YES	NO	YES	NO	YES	NO	
1. Are you, or any family member, whether or not listed on this application, now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	15. Complications of pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	29. Lung condition, emphysema, chronic obstructive pulmonary disease (COPD)	<input type="checkbox"/>	<input type="checkbox"/>
2. Positive test for HIV (human immunodeficiency virus) infection	<input type="checkbox"/>	<input type="checkbox"/>	16. Congenital disease/defect or mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	30. Mental or nervous conditions	<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"/>	31. Neurological conditions	<input type="checkbox"/>	<input type="checkbox"/>
4. Alcoholism, drinking condition, or drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	18. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	32. Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
5. Anemia or blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	19. Disorders of the female reproductive organs	<input type="checkbox"/>	<input type="checkbox"/>	33. Skin conditions	<input type="checkbox"/>	<input type="checkbox"/>
6. Arthritis or rheumatism Osteoarthritis _____ Rheumatoid _____	<input type="checkbox"/>	<input type="checkbox"/>	20. Disorders of the male reproductive organs including the prostate	<input type="checkbox"/>	<input type="checkbox"/>	34. Stomach conditions or ulcers	<input type="checkbox"/>	<input type="checkbox"/>
7. Asthma or chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	21. Epilepsy or seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	35. Stroke or paralysis	<input type="checkbox"/>	<input type="checkbox"/>
8. Attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>	22. Eye, ear, nose, or throat condition	<input type="checkbox"/>	<input type="checkbox"/>	36. Thyroid or pituitary condition	<input type="checkbox"/>	<input type="checkbox"/>
9. Back or joint condition	<input type="checkbox"/>	<input type="checkbox"/>	23. Gallstones or gall bladder condition	<input type="checkbox"/>	<input type="checkbox"/>	37. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
10. Bladder or kidney condition	<input type="checkbox"/>	<input type="checkbox"/>	24. Heart or cardiovascular condition	<input type="checkbox"/>	<input type="checkbox"/>	38. Tumor, growth, or cyst	<input type="checkbox"/>	<input type="checkbox"/>
11. Bodily deformity	<input type="checkbox"/>	<input type="checkbox"/>	25. Hemorrhoids or rectal condition	<input type="checkbox"/>	<input type="checkbox"/>	39. Ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>
12. Bone infection	<input type="checkbox"/>	<input type="checkbox"/>	26. High blood pressure If yes, last reading _____	<input type="checkbox"/>	<input type="checkbox"/>	40. Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
13. Cancer If skin, type _____ If Cancer, specify type _____	<input type="checkbox"/>	<input type="checkbox"/>	27. Injuries or accidents If broken bones, are there pins or hardware?	<input type="checkbox"/>	<input type="checkbox"/>	41. Has anyone who resides in your household smoked tobacco during the twelve months preceding this application?	<input type="checkbox"/>	<input type="checkbox"/>
14. Colon or intestinal condition	<input type="checkbox"/>	<input type="checkbox"/>	28. Liver condition, cirrhosis, or hepatitis. If hepatitis, type _____	<input type="checkbox"/>	<input type="checkbox"/>	42. Dementia, Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>

If you checked YES to any question above, please provide details below (please use extra paper if necessary):

Item No.	Person Affected	Mo./ Year	Name of Disease, Symptom, or Condition – Include Type of Treatment	Name of Hospital and Number of Days	Date Last Treated	Was Recovery Complete?	Drugs – Include Type or Name	Name of Physician

To Request Coverages
(Please read and sign the below **statement of understanding**):

By signing this application, I represent that all my answers are complete and accurate, and that I understand and agree to the following conditions:

- I agree to abide by all of the terms and conditions of the group policy.
- If I decline to enroll any eligible family member on this application or a newly-eligible family member at a later date, I must complete, sign, and return to the insurer the Employee's Waiver of Health Care Coverage area of this form (located below).
- No independent producer, agent or employee of the insurer or of my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The insurer may, at its discretion, request supplemental information from me, any family member listed on this application or any health care provider.
- On behalf of myself and all enrolled family members, I understand 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 my employer, including but not limited to increasing premiums.
- If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by the insurer.
- I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.
- As proof of status of employment, I authorize my employer to release to the insurer appropriate documents, including but not limited to, W-2 Wage and Tax Statements and other wage and tax summaries or forms.
- For individuals over the age of 19, Preexisting condition waiting period: There is a \$2,000 limit available under this policy for services, supplies, drugs or other charges that are provided within 12 months.

A preexisting condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the enrollment date. A pregnancy existing on the enrollment date is not a preexisting condition under this policy. Genetic information shall not be considered as a preexisting condition in the absence of a diagnosis of the condition related to such information. In certain circumstances, qualifying previous coverage may be credited toward the preexisting condition waiting period.

- If you have had group or individual health coverage or a government health care program for at least 12 months, you are entitled to receive a Certificate of Creditable Coverage from your previous employer or insurance company. This document will state the effective date of prior coverage and the termination date of coverage for you and any covered dependents. Your previous employer or insurance company will furnish you this certificate upon request.
- My employer's master group policy is the document that sets forth all terms of my coverage, and no independent producer, agent or other person can change the terms of the master group policy, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of the insurer.
- I agree that a facsimile or photocopy of my signature will serve the same as an original.
- I understand that this application will become part of the contract between the insurer and my employer.

• I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.

X _____
Applicant's Signature *Date*

Employee's Waiver of Health Care Coverage
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 for waiving coverage:

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

X _____
Applicant's Signature *Date*