



**3. Declination... Complete this section only if you want to decline coverage(s) for yourself and/or any eligible dependent(s).**

Type of Coverage:	Declined for:	Please write "A", "B", "C", etc., per the list below to identify the reason for declining (proof of other coverage may be required).
Dental plan	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	A Covered by another group plan; carrier and ID are:
Vision plan	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	B Covered by individual policy; carrier and ID are:
Life	<input type="checkbox"/> Self <input type="checkbox"/> Dependent(s)	C Covered by military service insurance
Disability	<input type="checkbox"/> Self  Not available if employee declined life coverage	D Have no other insurance coverage and am not interested  E Other: _____

**I UNDERSTAND THAT:**

- If I decline coverage under a PPO policy and have no other group or individual health coverage at this time, my dependent(s) and I may enroll as a late entrant(s), subject to an 18-month pre-existing condition waiting period.
- If I decline coverage under an HMO policy, I will not be able to enroll until the next open enrollment period.
- If I decline coverage for myself and/or my dependent(s) (including my spouse) because of other group or individual insurance coverage, I may in the future be able to enroll myself and/or my dependent(s) in this plan, provided that I request enrollment within 31 days after a qualifying event. In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependent(s), provided that I request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.
- I may be required to submit additional information upon request.
- If I decline life and/or disability coverage for any reason, my dependent(s) and I may enroll in the future as late entrants only if we provide satisfactory proof of insurability.

I hereby certify that I have been given the opportunity to participate in my employer's group insurance plan(s) underwritten by the company(ies) indicated on this enrollment application. The plan has been explained to me, and I decline to participate.

X \_\_\_\_\_ Date \_\_\_\_\_  
Employee signature if declining coverage for self/dependent(s)

**4. Authorization... The following Authorization is to be signed by ALL EMPLOYEES applying for coverage:**

**I AM APPLYING FOR LIFE AND/OR DISABILITY COVERAGE:** I understand that I am submitting this application to Anthem Life Insurance Company and that if one or more of the following circumstances apply, then the health history information on my Colorado Uniform Employee Application for Small Group Health Benefits Plans will be used by Anthem Life to determine whether or not life and/or disability insurance will be offered to me. 1) the date of this application is more than thirty-one (31) days after my eligibility date for coverage; 2) the amount of term life coverage I am applying for is more than the guaranteed issue limit; 3) I am applying for long term disability coverage and my employer has less than 6 enrolled employees. I understand that if I am not actively at work on the date my insurance would otherwise become effective, the insurance will not become effective until I return to active work.

Signature of Employee (if applying for life and/or disability coverage): X \_\_\_\_\_

I understand that the coverage I am applying for is subject to eligibility requirements. I acknowledge that I have read all sections of this application, including the information on the back pages, and certify that I agree to all matters covered herein. I also acknowledge that all information provided on this application is complete and accurate to the best of my knowledge. I understand and agree that this application shall become part of the contract between Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado and me.

Employee Signature	Date	Spouse Signature (if applying for coverage)	Date
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## 5. Employee Authorization, Notice and Representations for Life and/or Disability Coverage

My signature on page 2 of this application acknowledges my agreement with the authorization below.

I understand that Anthem Life Insurance Company (Anthem Life) may collect personal information about me from outside sources and that both personal and privileged information may be disclosed to outside parties without my authorization only if such disclosure is permitted by applicable federal and state law. I also understand that under applicable federal and state law, I have a right to see and correct personal information that Anthem Life collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem Life.

For the purpose of evaluating my health statement for Anthem Life coverage, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility; insurance company; the Medical Information Bureau, Inc.; or other organization, institution or person that has any records or knowledge of me or my health or that of my family for whom this health statement is made or their health to give Anthem Life or its reinsurers any such information. I also authorize Anthem Life or its reinsurers to release any information regarding me or my health or that of my family for whom insurance application is made to the Medical Information Bureau Inc.; or other life insurance companies with which I have policies or to which I may apply; and other insurers to which a claim for benefits may be submitted. I understand this information will be used by Anthem Life to determine eligibility for insurance. This information includes any record or knowledge about medical history, including information contained in such records relating to sensitive services such as mental health, psychiatric, substance abuse and reproductive health, and information about the HIV virus or AIDS or sexually transmitted or other communicable diseases. This includes but is not limited to all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, and insurance and billing information for treatment or services rendered by any provider. This authorization, for purposes of processing this application, will be valid from the date signed for a period of 30 months, and a photocopy of this authorization will be as valid as the original. I understand that I may request a photocopy. For the purposes of processing a claim under this coverage, this authorization is valid for the duration of the claim.

I certify that I have read, or have had read to me, the completed health statement and that I realize any false statement or misrepresentation in the health statement may result in loss of coverage under the policy.

### EMPLOYEE REPRESENTATIONS FOR LIFE AND/OR DISABILITY COVERAGE

Your signature on this application acknowledges your agreement with the following representations:

1. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries surviving the insured. Payment of proceeds shall be made in accordance with the terms of the group contract subject to change by my written notice to my employer.
2. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder. I understand that by applying for the type of coverage checked, I authorize deduction from my wages, if necessary, for the required premium for the coverage for which I have applied.
3. I am responsible for the timely notification to my employer of any changes that would make me or a dependent ineligible for coverage.
4. I am applying for the coverage selected on this application. If I select a coverage, or a combination of coverages, not available to me and/or in a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.
5. I understand that Anthem Life reserves the right to accept or decline this application and that no right whatsoever is created by this application.

I acknowledge that I have read the foregoing provisions and I expressly accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge, and I understand they are being relied on by the insurer in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s). A photocopy is as valid as the original.

I give this representation for and on behalf of myself and my eligible dependents, including my children and my spouse if covered by the plan. I am acting as their agent and representative.

The employee and any person authorized to act on behalf of the employee is entitled to receive a copy of this representation and will be provided a copy of this application upon request.

### IMPORTANT NOTICE

Information regarding your insurability will be treated as confidential. Anthem Life or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is PO Box 105, Essex Station, Boston, MA 02112.

Anthem Life or its reinsurers may also release information in its file to other insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. You may want to keep a copy of this statement for your records.



## COLORADO UNIFORM EMPLOYEE APPLICATION FOR SMALL GROUP HEALTH BENEFIT PLANS

Employee Name:		Employer Name:	
Proposed Effective Date:		Group Number (if known):	

**This form is designed for an employee's initial application for coverage. Please contact your agent or the carrier to determine if this form should be used in other situations once the group is enrolled with the carrier.**

### EMPLOYEE & DEPENDENT INFORMATION

Employee Instructions: Please **type or print** using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought.

Last Name:		First Name:		Middle Initial:					
Social Security #:		Date of Birth:	/ /	Sex:		Height:		Weight:	
Address:				City:					
County:				State:			Zip:		
Home Phone:			Email:				<input type="checkbox"/> Home	<input type="checkbox"/> Work	
What is your job title at your current employer?				Work Phone:					
What was your first day of employment?			How many hours, on average, do you work each week?						
Are you (check one):	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Common Law*	<input type="checkbox"/> Legally Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widow or Widower			
* A common law certification may be required by the carrier									
Are you on COBRA or State Continuation?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Start Date:			Stop Date:		
Please select the type of coverage for which you are applying from the plans offered by your employer and issued by the carrier:									
Medical Plan Name:			Primary Care Physician Name:						
Primary Care Physician Address:									

List all dependents (spouse and child(ren)) applying for coverage. Please list the medical plan for which you are applying from the plans offered by your employer and issued by the carrier. If you need additional space, please use a separate sheet of paper and attach it to this application (please print your name and sign and date the additional sheet).

<b>Spouse Name:</b>				Relationship:	Spouse				
Social Security #:		Date of Birth:	/ /	Sex:		Height:		Weight:	
Medical Plan Name:			Primary Care Physician Name:						
Primary Care Physician Address:									
<b>Dependent Name:</b>				Relationship:	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____				
Social Security #:		Date of Birth:	/ /	Sex:		Height:		Weight:	
Medical Plan Name:			Primary Care Physician Name:						
Primary Care Physician Address:									
Please check all that apply for the Dependent listed above*:									
<input type="checkbox"/> Full Time Student (Over Age 19 Under 24)		<input type="checkbox"/> Financially Dependent or Same Household (Over Age 19 Under 25)			<input type="checkbox"/> Disabled (Indicate reason) _____ (Over Age 19)				
<b>Dependent Name:</b>				Relationship:	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____				
Social Security #:		Date of Birth:	/ /	Sex:		Height:		Weight:	
Medical Plan Name:			Primary Care Physician Name:						

\*If you check any of the boxes in this section the carrier may require additional information to determine eligibility of the dependent.

*This section continued on the next page...*

Employee Name:	Employer Name:
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Primary Care Physician Address:	
Please check all that apply for the Dependent listed above*: <input type="checkbox"/> Full Time Student (Over Age 19 Under 24) <input type="checkbox"/> Financially Dependent or Same Household (Over Age 19 Under 25) <input type="checkbox"/> Disabled (Indicate reason) _____ (Over Age 19)	
Dependent Name:	Relationship: <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____
Social Security #:	Date of Birth:    /    /    Sex:    Height:    Weight:
Medical Plan Name:	Primary Care Physician Name:
Primary Care Physician Address:	
Please check all that apply for the Dependent listed above*: <input type="checkbox"/> Full Time Student (Over Age 19 Under 24) <input type="checkbox"/> Financially Dependent or Same Household (Over Age 19 Under 25) <input type="checkbox"/> Disabled (Indicate reason) _____ (Over Age 19)	

\* If you check any of the boxes in this section the carrier may require additional information to determine eligibility of the dependent.

**EMPLOYEE/DEPENDENT WAIVER OF COVERAGE**

Complete this section ONLY if you are not enrolling yourself or your spouse or dependents. Waiver must be completed for all of your dependents to be eligible for enrollment on this plan in the event of changing circumstances. I understand that I am eligible to apply for group health coverage through my employer. I do **NOT** want, and hereby waive, group health coverage for:

	Name (Last, First, MI)	Birth Date (Mo/Day/Year)
Employee		
Spouse		
Dependent 1		
Dependent 2		
Dependent 3		

I am **waiving** group health coverage for myself and/or the dependents listed above because (check all that apply, **copy of ID card may be required**):

- I am covered under my spouse's group policy.
- My spouse is covered under another plan (including this plan, if spouse is also an employee).
- My dependents are covered under another plan.
- I wish to continue other coverage obtained through an Individual Plan or Medicare
- Other (Please explain): \_\_\_\_\_

**WAIVER:** I certify that I have been given the opportunity to apply for group health coverage and decline to enroll as indicated above, on behalf of myself, my spouse and my dependent child(ren). I understand that by signing this waiver, I, my spouse, and my dependent child(ren) forfeit the right to coverage. I was not pressured, forced or unfairly induced by my employer, the agent or the carrier(s) into waiving or declining the group health coverage. If in the future I apply for coverage, I, my spouse, or any of my dependent child(ren) may be treated as a late enrollee and subject to postponement of coverage for up to 12 months or an exclusion of coverage for preexisting conditions for a period of up to 18 months. Any preexisting condition period may be offset by the time I, my spouse or my dependent child(ren) were covered under a qualified health plan. I understand that if I am declining enrollment for myself, my spouse, or my dependent child(ren) because of other health coverage, I may, in the future, be able to enroll myself, my spouse, or my dependent child(ren) in this plan, as required by law, provided that I request enrollment within 30 days after my other health coverage ends or a qualifying event occurs. **If I do not request enrollment within 30 days of the above events, I understand that I may not be able to enroll for coverage until my company's Open Enrollment period. I understand that I can obtain information related to my enrollment eligibility from my employer or small group health carrier.**

Signature of Employee: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Employee Name:	Employer Name:
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**CURRENT AND PREVIOUS MEDICAL COVERAGE**

The information you provide about your other individual or group health coverage (either prior or current) is necessary to determine whether you will have any waiting periods for preexisting conditions under the group health coverage plan for which you are applying. Your information will also help the small employer carrier(s) to coordinate benefits with any other group health coverage you may have.

**#1 Do you, your spouse or your dependent child(ren) listed in this application currently have health coverage?**  
Yes No

**#2 Have you, your spouse or your dependent child(ren) listed in this application had previous health coverage within the last 90 days?** Yes No

If you marked question #2 "Yes" please complete the following table and attach a copy of the Certificates of Creditable Coverage for each person.

Starting with you, the employee, identify each person applying for coverage and include information for all current and previous health coverage(s) in effect during the last 18 months.

If you need additional space, please use a separate sheet of paper and attach it to this application (please print your name and sign and date the additional sheet).

<b>Employee Name:</b>		Date Coverage Started:		Date Coverage Ended:	
Carrier Name:		Carrier Phone Number:		Type of Coverage (See Key):	
Group Number:		Subscriber ID #:		Reason for Termination:	
Is Current Coverage an HSA qualified High Deductible Health Plan?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Is the plan information listed above the same for your spouse and all dependents? If yes, skip to next section.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Spouse Name:</b>		Date Coverage Started:		Date Coverage Ended:	
Carrier Name:		Carrier Phone Number:		Type of Coverage (See Key):	
Group Number:		Subscriber ID #:		Reason for Termination:	
Is Current Coverage an HSA qualified High Deductible Health Plan?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Dependent Names:</b>		Date Coverage Started:		Date Coverage Ended:	
Carrier Name:		Carrier Phone Number:		Type of Coverage (See Key):	
Group Number:		Subscriber ID #:		Reason for Termination:	
Is Current Coverage an HSA qualified High Deductible Health Plan?		<input type="checkbox"/> Yes <input type="checkbox"/> No			

**Type of Coverage Key:** **G** = Group Comprehensive Major Medical; **I** = Individual Comprehensive Major Medical; **MS** = Medicare Supplement; **H** = Hospital Coverage Only; **V** = Vision Coverage Only **O**=Other, please explain: \_\_\_\_\_

**MEDICARE INFORMATION**

**If you need to complete this section for more than one person, please use a separate sheet of paper and attach it to this application (please sign and date the additional sheet). A copy of your ID card may be required.**

Are you, your spouse or your child(ren) covered by:					
Medicare Part A?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Part B?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Part D?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," reason for Medicare:					
<input type="checkbox"/> 65+	<input type="checkbox"/> Disability	<input type="checkbox"/> End-Stage Renal Disease (ESRD) Eff. Date_____	<input type="checkbox"/> Disability and ESRD Eff. Date_____		
Name of person covered by Medicare:					

Employee Name:	Employer Name:
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**MEDICAL INFORMATION**

**You are NOT required to share this information with your employer. You may, at your discretion, return this completed application in a sealed envelope. Please write your name on the outside of the envelope for easy identification.**

Please answer the following questions to the best of your knowledge. On the next page, please provide the complete details if you answer "Yes" to any of the questions below. The date that this application is signed is the date which you should use when answering questions that request you to provide prior history for a period of time.

**This health questionnaire must be updated to include any change in health status that occurs between the date of application and the effective date.**

Are you, your spouse or any dependent child(ren) currently pregnant or an expectant parent?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "Yes," please indicate due date:	Twins or Other Multiple(s) Expected?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Complications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	C-Section Expected?	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the past 5 years, has anyone named in this application been treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Has anyone named in this application used tobacco products during the past 12 months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "Yes," please complete the following:			
Name (s):	<input type="checkbox"/> Cigarettes	<input type="checkbox"/> Chewing tobacco	<input type="checkbox"/> Pipe/Cigars
Duration?	Frequency?		
In the past 5 years, has anyone named in this application been evaluated or treated for alcoholism or chemical dependency; or joined any organization for alcoholism or chemical dependency; or used illegal drugs; or been advised by a health care professional to reduce the use of alcohol or illegal drugs?			<input type="checkbox"/> Yes <input type="checkbox"/> No
In the past 5 years, has anyone named in this application sustained an injury as a result of an auto or work related accident?			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Within the past 5 years, has anyone applying for coverage been counseled, or consulted or treated for any of the following:</b>			
1.	Heart disease or disorder, stroke, circulatory disorder, chest pain, high or low blood pressure, anemia or blood disorder, elevated cholesterol and or/triglyceride levels or any other circulatory system issue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Ulcers, stomach disorder, liver/pancreas disorder, hernia, gallbladder disorder, rectal disorder, intestine disorder, esophageal disorder, hepatitis, colitis, Crohn's disease or any other digestive system issue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Urinary tract/kidney/bladder disorder, prostate disorder, renal failure, menstrual disorder, genital disorder, sexual dysfunction, infertility, dialysis, sexually transmitted disease, pregnancy complications (e.g., premature birth, miscarriage, C-Section), breast disorder or other genitourinary system issue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Connective tissue disorder, thyroid disorder, adrenal disorder, diabetes, enlargement of the lymph-nodes, lymph system disorder, pituitary disorder, any growth disorder or other endocrine system issue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Allergy(ies), asthma, emphysema, sinus or nasal disorder, lung disease or disorder, shortness of breath, sleep apnea or other respiratory system issue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	Arthritis, fibromyalgia, back/neck disorder, joint /bone disorder, knee disorder, carpal tunnel, skin disorder, chronic fatigue syndrome or other musculoskeletal issue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Brain disorder, aneurysm, paralysis, central nervous system disorder, cerebral palsy, epilepsy or other seizures, headaches, multiple sclerosis or other nervous system issue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Cancer, tumor, abnormal growth, cyst or carcinoma-in-situ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	Eye or ear disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10.	Attention deficit disorder, psychological disorder, suicide attempt, depression, anxiety, autism or other behavioral health issue or biologically based mental illness (schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, panic disorder)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11.	Organ or other type of transplant or implant (including breast implants), gastric bypass, physical deformity or defect including cleft lip or cleft palate, prosthetic device, congenital disorder, down's syndrome?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12.	Within the last 5 years, has anyone named in this application to be covered by this coverage had any other injury, illness or treatment for any condition not already listed; been hospitalized or been scheduled for hospitalization; had surgery or had surgery scheduled; had a test or a test scheduled; or been recommended to have a test or surgery which was not performed for any reason not already mentioned in this application? <i>We are NOT seeking the results of HIV Antibody Test.</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Employee Name:	Employer Name:
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If you answered, "Yes" to any of the questions or conditions on the previous page please list and provide the complete details in the space provided below.

**(Attach additional pages as needed. Please print your name and sign and date the additional pages.)**

Name of Person	Date(s) of Treatment	Question Number	Give full details for each question answered "Yes," state the condition, duration and degree of recovery. If accident or injury, also indicate if auto or work related.	Name and address of attending physician or other health care provider.

If anyone named in this application is taking medication or was prescribed or recommended any medication during the period of time related to your answer (i.e. past 5 years or currently taking), please list all of those medications, dosages, and what medical condition is being treated or were treated by each medication in the space provided below.

**(Attach additional pages as needed and sign and date the additional pages.)**

Name of Person	Name, dosage and frequency of medication <i>(include illness or health condition for which medication was prescribed)</i>	Date(s) medication taken <i>(indicate if ongoing)</i>	Name and address of prescribing physician or licensed health care provider

Employee Name:	Employer Name:
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**TERMS AND CONDITIONS**

I acknowledge that I have read all sections of this Colorado Uniform Employee Application for Small Employer Group Health Coverage (Application), and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge. I understand and agree that neither my employer nor any insurance agents have any authority to waive my complete answer to any question, agree to insurability, alter any contract, or waive any Colorado small employer carrier's other rights or requirements.

I hereby apply for enrollment for myself and for my eligible family dependents listed. On behalf of my eligible family dependents and myself, I agree to all of the terms and conditions of the group contract(s) with Colorado small employer carrier(s) under which I wish to enroll for coverage. I have indicated in this Application, if required, what product(s) or provider(s) I have selected. **I agree that no coverage will be effective until the date specified by the Colorado small employer carrier(s) with whom I enroll, after this application has been accepted by such carrier(s).**

I understand and agree that any information obtained in connection with this Application will be used by Colorado small employer carrier(s) to determine eligibility for coverage, underwriting and for any other purposes related to providing coverage. On behalf of my eligible family dependents and myself, I authorize any provider of health services or supplies, insurance company, health care clearinghouse, pharmacy benefit manager, and any other person with knowledge or records to release information to any Colorado small employer carrier, its agents and legal representatives, about any and all health-related services and supplies provided or to be provided to me or my eligible family dependents.

**It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.**

When applicable, I authorize my employer to deduct contributions from my earnings to be applied to the cost of coverage.

I agree to any applicable group contract provisions for the resolution of disagreements and disputes, including arbitration when required and as allowed by law. Please refer to any arbitration provisions in the group contract(s).

I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document will become a part of the contract when coverage is approved and issued.

**Signature of Employee:** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

Employee Name:

Employer Name:

## DISCLOSURES

**COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.**

Please be advised that a carrier may not request or require medical information going back more than five (5) years before the date of application. Additionally, the carrier cannot use medical information that is more than five (5) years old on any of the enrollee members of a small group in underwriting or setting premiums for the group.

### Preexisting Conditions

A preexisting condition means 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 within six (6) months preceding the date of enrollment or, if earlier, the first day of the waiting period for enrollment.

A preexisting condition limitation provision does not apply to pregnancy, a newly adopted child, a child placed for adoption, nor to a child who is enrolled within 30 days after birth.

A preexisting condition limitation provision **DOES NOT** apply to any of the mandated Colorado basic or standard HMO health benefit plans.

If the health benefit plan for which you are enrolling has a preexisting condition limitation provision, the following statements apply:

- This limitation period shall be no longer than six (6) months (12 months for business groups of one) for all new enrollees.
- For late enrollees, the limitation period may be up to 18 months.

The preexisting condition limitation period will be reduced by the period of time that a new enrollee was covered by creditable coverage, provided that the creditable coverage did not terminate more than 90 days before the earlier of the first day of the waiting period or the effective date of coverage. The health coverage policies or plans that count as "creditable coverage" can reduce the length of a preexisting condition limitation period depending on the amount of time the new enrollee was covered by the creditable coverage.

### Late Enrollee

A late enrollee is an eligible employee or dependent who requests enrollment in a group health benefit plan following the initial enrollment period for which the individual was entitled to enroll under the terms of the health benefit plan, as long as the initial enrollment period was a period of at least 30 days.

### Creditable Coverage

Creditable coverage as defined in § 10-16-102(13.7), C.R.S., means benefits or coverage under:

- Medicare or Medicaid;
- An employee welfare benefit plan or group health insurance or health benefit plan;
- An individual health benefit plan; a state health benefits risk pool (including but not limited to CoverColorado); or
- Coverage provided under Chapter 55 of title 10 of the United States code, a medical care program of the federal Indian health service or of a tribal organization, a health plan offered under chapter 89 of title 5, United States code, a public health plan, or a health benefit plan under section 5(e) of the federal "Peace Corps Act" (22 U.S.C. Sec 2504(e)).

This document is a publication of the Colorado Division of Insurance. If you have questions about the content of this document please contact our offices at 303-894-7499 or visit our website at <http://www.dora.state.co.us/insurance>. For questions regarding coverage or enrollment please see your employer.

