

Application for Household Employee

Employer Information

1. The applicant household employee	Has been employed by me since Date: / /
2. I have employed at least one household employee on at least 50% of the days in a normal work week during the preceding calendar quarter.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. The household employee applicant is a full-time employee who works 24 or more hours per week on a permanent basis as a household employee.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. For initial qualification for enrollment of this employee, I am attaching a copy of the employee's quarterly employment-related tax and withholding statement for the past quarter.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I certify that the information stated above is correct and represents true facts and information. I understand that I may be required to provide employment related tax and withholding information, as requested by Rocky Mountain Health Plans, for continuing qualification and enrollment of the household employee identified above.

Household Employer Signature: _____ Date: _____

Employee Information

1. I am a full-time household employee who works 24 or more hours a week on a permanent basis.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. A substantial part of my income in at least one of the last three years has been earned from household employment.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I certify that the information stated above is correct and represents true facts and information. I also certify that my household employment with the employer noted above is not seasonal or temporary employment.

Household Employee Signature: _____ Date: _____

Colorado law requires carriers to make available a Colorado Health Benefit Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must provide the form, upon oral or written request, within three (3) business days to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

An access plan is available for each managed care network offered by Rocky Mountain Health Plans to any interested party upon request. Such access plans contain information on providers, hospitals, referral and grievance procedures, quality assurance, access for members with special needs, emergency coverage provisions, and other information on how to access services.

For small employer groups, see the enclosed Disclosure Notice for Small Employer Groups, which is incorporated into this document by reference.

Attestation for Business Group of One is on the back of this form.



Open Enrollment Certification for Business Group of One

For

RMHMO HMO Basic Limited Mandate Health Benefit Plan or Colorado

RMHMO HMO Standard Health Benefit Plan for Colorado

RMHCO PPO Basic Limited Mandate Health Benefit Plan for Colorado

RMHCO PPO Standard Health Benefit Plan for Colorado

(collectively referred to as Basic and Standard Plans)

The definition of a Business Group of One is: "An individual, a sole proprietor, or a single full-time employee of a subchapter S corporation, C corporation, nonprofit corporation, limited liability company, or partnership who works twenty-four (24) hours or more a week on a permanent basis and who has carried on significant business activity for a period of at least one year prior to application for coverage, has gross income as indicated on federal internal revenue service forms 1040; Schedule C, F, or SE; or other forms recognized by the federal internal revenue service for income reporting purposes which generated gross income from which that individual, sole proprietor, or single full-time employee has derived at least a substantial part of such individual's income for one year out of the most recent consecutive three-year period."

Enrollment Periods Offered for Rocky Mountain Health Plans Basic or Standard Health Benefit Plans

1.	2.	3.	4.
Within 31 days AFTER YOUR BIRTHDAY; or	Within the 31-day time period of the date you exhaust federal or state law continuation of coverage (COC) such as COBRA or Colorado COC; or	Within 31 days after the one year anniversary of the business start date, UNLESS your birthday is within the same 31 days; or	Within 31 days of your involuntary loss of creditable health coverage

Please complete the questions below to determine your eligibility for open enrollment in a Rocky Mountain Health Plans Basic or Standard Health Benefit Plan.

Eligibility

Business Name:	Applicant Name:	Applicant Date of Birth:
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1. What is the official date when you commenced working as a Business Group of One?	MM / DD / YY
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2. Are you applying for health coverage due to recent exhaustion of federal or state law continuation of coverage, such as COBRA or Colorado Continuation of Coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," when did your COBRA or state law continuation of coverage end?	MM / DD / YY
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3. Are you applying for health coverage due to an involuntary loss of coverage from another health plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," when did you lose your coverage?	MM / DD / YY
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4. If "Yes" to question 3, please check the type of plan through which coverage was provided:	<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other (please describe):	<input type="checkbox"/> Group health benefit plan <input type="checkbox"/> State health benefits risk pool <input type="checkbox"/> Individual health benefit plan <input type="checkbox"/> A public health benefit plan	<input type="checkbox"/> Student health plan <input type="checkbox"/> A medical care program of the Federal Indian Health Service
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5. Describe the reason for the loss of coverage:

I certify that the information stated above is correct and represents true facts and information.

Employee Signature: _____ Date: _____



ROCKY MOUNTAIN

HEALTH PLANS®

We understand Colorado. We understand you.

Plans underwritten by Rocky Mountain HMO (RMHMO)	Plans underwritten by Rocky Mountain HealthCare Options (RMHCO)
Good Health Savings HSA HMO Rocky Mountain Good Health HMO Rocky Mountain VISTA PPO RMHMO HMO Standard Health Benefit Plan for Colorado RMHMO HMO Basic Limited Mandate Health Benefit Plan for Colorado	Good Health Savings HSA PPO Indemnity Plan Rocky Mountain Good Health PPO Rocky Mountain VISTA PPO RMHCO PPO Standard Health Benefit Plan for Colorado RMHCO PPO Basic Limited Mandate Health Benefit Plan for Colorado

Read important information below:

Colorado law requires carriers to make available a Colorado Health Benefit Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must provide the form, upon oral or written request, within three (3) business days to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

An access plan is available for each managed care network offered by Rocky Mountain Health Plans to any interested party upon request. Such access plans contain information on providers, hospitals, referral and grievance procedures, quality assurance, access for members with special needs, emergency coverage provisions, and other information on how to access services.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company 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.

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.

The pre-existing condition limitation period does not apply to the RMHMO HMO Basic Limited Mandate Health Benefit Plan for Colorado and the RMHMO HMO Standard Health Benefit Plan for Colorado. It also does not apply to pregnancy, a newborn, a newly adopted child, a child placed for adoption, nor to a child who is under 19 years of age.

RMHP will impose a six-month pre-existing condition limitation period (12-month limitation period for Business Groups of One) for all new enrollees (not including late enrollees) who have a physical or mental condition for which medical advice, diagnosis, care, supplies, prescription drugs, or treatment was recommended or received within six months immediately preceding the date of their enrollment in an RMHP plan or the first day of any employer-imposed waiting period, whichever is earlier. This means that if you have a medical condition before enrolling in our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. The pre-existing condition limitation period will be reduced by the period of time that a new enrollee was covered by creditable coverage, provided 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 under an RMHP plan. Such health coverage policies or plans that count as "creditable coverage" can reduce the length of any pre-existing condition limitation periods that might otherwise apply by the number of days of your prior creditable coverage. Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion limitation if you have not had a break in coverage of at least 90 days.

RMHP will impose an 18-month pre-existing condition limitation period for all late enrollees who have a physical or mental condition for which medical advice, diagnosis, care, supplies, prescription drugs, or treatment was recommended or received within six months immediately preceding the date of their enrollment in an RMHP plan. This 18-month period shall also include a 12-month period of exclusion from coverage that is applicable to late enrollees. The pre-existing condition limitation period for late enrollees will be reduced by the period of time that the late enrollee was covered by creditable coverage, provided the creditable coverage did not terminate more than 90 days before the date of their enrollment under an RMHP plan.

For small employer groups, see the enclosed Disclosure Notice for Small Employer Groups, which is incorporated into this document by reference.

Uniform Employee Application

Thank you for choosing Rocky Mountain Health Plans for your health care coverage! Here are some tips for completing the application.

- If you are applying for health care coverage with Rocky Mountain Health Plans as a Business Group of One, please complete the entire application. Employees of business groups with 2 or more eligible employees must complete the entire application except for pages 4 and 5.
- If you are not enrolling one or more of your eligible family members, complete the waiver on page 2 and sign it.
- Remember to sign and date pages 6 and 8.

Employee who does not want coverage with Rocky Mountain Health Plans

- If you are waiving coverage for yourself, please write "Waiving Coverage" at the top of page 1.
- Complete the following on page 1:
 - Employee Name/Employer Name/Social Security # /What is your job title at your current employer?/What was your first day of employment?/How many hours, on average, do you work each week?
- Complete the Employee/Dependent Waiver of Coverage on page 2 and remember to sign and date page 2.

Clarification on Application

Federal law requirements in effect for October 1, 2010 are not reflected in this application. Please note the following:

- Dependent children are eligible for coverage up to age 26. There is no requirement that the child be a full time student, or be financially dependent on or live in the same household as the subscriber.
- A preexisting condition limitation provision does not apply to anyone under the age of 19.

Employees who reside outside of Colorado or have dependents living outside of Colorado

- If you are enrolling on an HMO plan and you or your dependent(s) reside outside of Colorado, please write "PHCS" in the box labeled "Medical Plan" on page 1 or 2 for each family member who resides outside Colorado.
- If you are enrolling on a PPO plan and you reside outside of Colorado, please write "PHCS" in the box labeled "Medical Plan" on page 1.

MK453R1010

www.rmhp.org

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2775 Crossroads Blvd.
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970-244-7760

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303-689-7367

Durango
555 RiverGate Lane
Unit B1-109
Durango, CO 81301
970-385-5131

Pueblo
503 N. Main Street
Suite 718
Pueblo, CO 81003
719-253-3900

Patient Protection and Affordable Care Act Group Notices for Rocky Mountain Health Plans (“Your Plan”)

- I. Your Plan may require the designation of a primary care provider (PCP). A Member has the right to designate any PCP who participates in RMHP’s network and who is available to accept the Member as a patient. If required, until a Member makes this designation, a PCP will be designated for the Member. For information on how to select a PCP, and for a list of the participating PCPs, contact customer service at 970-243-7050 or 800-346-4643. For children, a pediatrician may be designated as the PCP. A Member does not need prior authorization in order to obtain access to obstetrical or gynecological care from a health care professional in RMHP’s network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact customer service at 970-243-7050 or 800-346-4643.

- II. Individuals who are dependents of eligible employees, are under twenty six (26) years of age, and who were not previously eligible due to age, marital status or financial independence, may now be eligible to enroll during either Your Plan’s Special Open Enrollment Period or the group’s Annual Open Enrollment Period. If such individuals are now eligible, they will be eligible for coverage until they turn twenty six (26) years of age. The Special Open Enrollment period is September and October, 2010 for either an October 1 or November 1, 2010 effective date.

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555 RiverGate Lane
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503 N. Main Street
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719-253-3900



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).

Spouse Name:		Relationship:	Spouse						
Social Security #:		Date of Birth:	/ /	Sex:		Height:		Weight:	
Medical Plan Name:				Primary Care Physician Name:					
Primary Care Physician Address:									
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)							
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:					

*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 <input type="checkbox"/> Financially Dependent or Same Household <input type="checkbox"/> Disabled (Indicate reason) _____ (Over Age 19 Under 24) (Over Age 19 Under 25) (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 <input type="checkbox"/> Financially Dependent or Same Household <input type="checkbox"/> Disabled (Indicate reason) _____ (Over Age 19 Under 24) (Over Age 19 Under 25) (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).

Employee Name:		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			
Is the plan information listed above the same for your spouse and all dependents? If yes, skip to next section. <input type="checkbox"/> Yes <input type="checkbox"/> No					
Spouse Name:		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			
Dependent Names:		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
Within the past 5 years, has anyone applying for coverage been counseled, or consulted or treated for any of the following:			
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.

