

Small Group Employee Application

For Groups of 2 - 50 Employees

For Employer Use NEW HIRE LATE ENROLLMENT STATUS CHANGE RETIREE EARLY RETIREE COBRA

NAME OF EMPLOYER Snakes R Us GROUP NUMBER _____ HIRE DATE 01/21/2005 EFF. DATE 07/16/2006

The following information is for your employers' records. Before submitting your application, please review all information to be sure it is complete. Then fold the application in half so this page is facing out, and staple.

I. Employee Information

FIRST NAME	M.I.	LAST NAME	DATE OF BIRTH	HRS. WORKED PER WK.	HIRE DATE
Lena	M	Vanderguild	12/16/1975	40	01/21/2005
HOME ADDRESS - STREET	CITY		STATE	ZIP CODE	COUNTY
123 ABC St Apt. 2	Somecity		MN	99201	Spokane
HOME PHONE (include area code)	WORK PHONE (include area code)		MARITAL STATUS		
5094485511	5094487711		<input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> DOMESTIC PARTNER <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED		

II. Plan Selection / Information - *Your plan selection may only be changed at your employer's renewal.*

Please select one of the following: Medical (complete A) Dental (complete B) Medical and Dental (complete A and B)

A. IF MEDICAL PLAN, PLEASE INDICATE PLAN NAME:

Plan name: _____

I am applying for coverage for: (check all that apply)

- Myself
 My spouse Date of birth _____
 My dependent children Number of children 2
 Domestic partner
(please consult your employer)

B. IF DENTAL PLAN, PLEASE SELECT ONE OF THE FOLLOWING: (Ask your employer if dental is offered)

- Single Dental Family Dental Waiving Dental Coverage because:
 Have other coverage
 Do not want coverage

III. Waiver of Coverage - *This section MUST be completed if you or your dependents DO NOT want coverage.*

I understand that I am eligible to apply for health coverage through my employer. **I DO NOT** want coverage for:

- Myself, my spouse or my dependent child(ren) My spouse My dependent child(ren)

Please indicate the reason you are waiving coverage. I am declining coverage at this time because I or my dependents have coverage provided through:

- Spouse's Group Plan Medicare ___A or A & B___ Group Coverage Continuation (COBRA) Individual Policy
 Medical Assistance General Assistance
 I (and/or my family member(s)) choose to be without health insurance. Other, **explain:** _____

I understand that if I decide to apply for coverage at a later date, a pre-existing condition exclusion may apply.

PRINT NAME

Electronically signed by: Lena M Vanderguild
SIGNATURE OF EMPLOYEE (REQUIRED IF YOU OR FAMILY MEMBERS ARE WAIVING COVERAGE)

07/26/2006
DATE SIGNED

IV. Applicant Information - List all family members to be covered.

EMPLOYEE:

NAME: FIRST, M.I., LAST SOCIAL SECURITY NUMBER	DATE OF BIRTH (M/D/YYYY)	AGE	RELATIONSHIP	SEX (M/F)	HEIGHT	WEIGHT	DENTAL CLINIC # (if available)
NAME <u>Lena M Vanderguild</u> SOC. SEC. # <u>548798888</u>	<u>12/16/1975</u>	<u>30</u>	<u>SELF</u>	<u>F</u>	<u>5'4"</u>	<u>125lbs</u>	<input type="checkbox"/> TIER I Clinic # _____ <input type="checkbox"/> TIER II

DEPENDENTS: (INDICATE LAST NAME ONLY IF DIFFERENT THAN EMPLOYEE)

NAME <u>Amy Vanderguild</u> SOC. SEC. # <u>555555555</u>	<u>03/31/1987</u>	<u>19</u>	<u>Child</u>	<u>F</u>	<u>5'2"</u>	<u>100 lbs</u>	<input type="checkbox"/> TIER I Clinic # _____ <input type="checkbox"/> TIER II
NAME <u>Brad Anderson</u> SOC. SEC. # <u>444444444</u>	<u>02/14/1995</u>	<u>11</u>	<u>Stepchild</u>	<u>M</u>	<u>4'6"</u>	<u>85 lbs</u>	<input type="checkbox"/> TIER I Clinic # _____ <input type="checkbox"/> TIER II
NAME _____ SOC. SEC. # _____							<input type="checkbox"/> TIER I Clinic # _____ <input type="checkbox"/> TIER II
NAME _____ SOC. SEC. # _____							<input type="checkbox"/> TIER I Clinic # _____ <input type="checkbox"/> TIER II
NAME _____ SOC. SEC. # _____							<input type="checkbox"/> TIER I Clinic # _____ <input type="checkbox"/> TIER II
NAME _____ SOC. SEC. # _____							<input type="checkbox"/> TIER I Clinic # _____ <input type="checkbox"/> TIER II

Do all of the dependent(s) listed above reside at the same address as the employee? YES NO
 If NO, list dependent(s) name and address: Brad Anderson 123 College Way Somplace, WA 12345
 Do you want the individual's materials to go to this address? YES NO
 If last name is different from dependents, please explain why Stepchild
 Are any of the above listed dependent(s) age 19 or older, full-time students? YES NO
 If YES, indicate the name, school attending and status:

NAME OF STUDENT	SCHOOL ATTENDING	STATUS
<u>Brad Anderson</u>	<u>Someschool</u>	<input type="checkbox"/> Part-time <input checked="" type="checkbox"/> Full-time
_____	_____	<input type="checkbox"/> Part-time <input type="checkbox"/> Full-time

V. Other Medical Insurance Information - This section must be completed. If not completed, coverage will be limited.

1. Do you or any family members included in this application currently have or had any health coverage within the past 18 months?
 Yes No **If yes, you must provide coverage history for the past 18 months in the spaces below:**

Person's name	Insurance company name, city and state telephone number / policy number	Effective date	Termination date	Reason for termination
<u>Brad Anderson</u>	<u>ABC Company A12345</u>	<u>01/22/2005</u>		
_____	_____	_____	_____	_____

2. Are you or your spouse covered by Medicare Part A or Part B? Yes No If yes, please attach copy of Medicare card.

Name: Lena M Vanderguild

VI. Health Information - Please answer questions 1-5

1. Have you or any family member applying for coverage EVER been treated for, or diagnosed with, any of the following conditions? YES NO
(If yes, check all that apply below)

- a. asthma
 - b. cancer
 - c. diabetes
 - d. arthritis
 - e. seizure/epilepsy
 - f. DWI / DUI - date: _____
 - g. respiratory disorder
 - h. immune system disorder
 - i. allergies
 - j. blood disorder
 - k. thyroid disorder
 - l. muscle, bone or joint disorder
 - m. heart or circulatory disorder
 - n. reproduction system disorder
 - o. eating disorder
 - p. headache/migraine
 - q. psychological or neurological disorder
 - r. digestive or intestinal disorder
 - s. kidney or urinary tract disorder
 - t. high blood pressure
 - u. counseling services
 - v. eye or ear disorder
 - w. non-cancerous tumor
 - x. stroke
 - y. liver disorder
 - z. mental deficiency
 - aa. alcohol abuse
 - bb. drug abuse
 - cc. other (provide detail below)
- dd. currently have a condition that may require surgical or hospital care (explain): _____
- ee. been hospitalized or had surgery for any condition or injury (explain): _____

2. Are any of these conditions related to a workers' compensation injury, motor vehicle accident or third party liability claim? YES NO

3. Have you or a family member applying for coverage used tobacco products in the last 12 months? YES NO Name & quit date: _____
(If this question is not answered, we will assume that there is a tobacco user applying for coverage)

If you have checked ANY condition above, please explain with details below:

PERSON'S NAME	DIAGNOSIS AND DETAILS ABOUT CONDITION, TREATMENT	DATE OF DIAGNOSIS	DATE OF RECOVERY	DAYS IN HOSPITAL
Lena Vanderguild	1r Peptic Ulcer	2005	ongoing	0
Lena Vanderguild	1z Shingles	2001	n/a	0
John Vanderguild	1m High Cholesterol, take medications and frequent doctor visits	2001	n/a	0
John Vanderguild	1i Hayfever and other allergies take medications	1995	ongoing	0
Amy Vanderguild	1i Hayfever and allergy to pennicillin	1995	ongoing	0
Amy Vanderguild	1a Asthmatic and uses nebulizer with regular checkups	1997	ongoing	0
Amy Vanderguild	1u Councelling	2000	n/a	0
See Attached	See Attached	See Attached	See Attached	See Attached

4. Are you, your spouse, significant other, or dependents currently pregnant? YES Due date: See Attached NO

If YES, please provide name, relationship: See Attached

- a) Is a C-section anticipated? YES NO
- b) Has a C-section been performed in the past? YES NO
- c) Are multiple births expected? YES NO
- d) Has the pregnancy induced hypertension? YES NO
- e) If ultrasounds have been performed, please list how many: See Attached
- f) Has Gestational Diabetes been diagnosed? YES NO

5. Is anyone currently taking, or taken during the past twelve months, any prescribed medication? YES NO If YES, list below.

PERSON'S NAME	MEDICATION	REASON PRESCRIBED	DOSAGE (mg / gm)	# PER DAY	REFILLS PER YR.	STILL PRESCRIBED?
Lena Vanderguild	Nexium	Peptic Ulcer	25 mg	1	12	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Amy Vanderguild	Primatene Mist	Athsma	10 mg	n/a	5	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

VII. Employee's authorization and representation - Read this section carefully, sign and date the application.

I hereby apply for coverage on the basis of the statements and answers to the questions herein. I hereby declare all answers to be true to the best of my knowledge and to accurately represent the health of those persons applying for coverage and waiving coverage. I understand that these statements, answers and subsequent information I provide are the basis for my coverage. Furthermore, I understand that this application must be updated by me to include any condition or disease which may occur between the date of my application and the Effective Date of Coverage. **I understand that if my application for new or additional coverage is accepted, that applicable coverage will not be effective until after I am notified of the Effective Date.**

Electronically signed by: Lena M Vanderguild
SIGNATURE OF EMPLOYEE

07/26/2006
DATE SIGNED

Health Conditions Information

Ques. #	Name	Onset Date	Recovery Date	Doctor Info
1q	Brad Anderson	1998	n/a	Dr Doctorman 123 Some Way Somecity WA 12345
Taking medicaiton in cycles meets with doctor				

Pregnancies Information

Name	Due Date	Complications
Lena Vanderguild	05/15/2006	3 ultrasounds