DeanHealthPlan Administrative Services
A member of SSM Health

Level-Funded Employee Application for Group Coverage

Employer Name:	Group Number:	Effective Date:
Employee Plan Selection:	Employee Class:	

Section A

1) Employee name (Last, First, Middle)				
2) Street or Post Office address	3) City	4) County	5) State	6) Zip Code

7) Home phone number ( )	8) Work phone number ( )	9) Cell phone number ( )

10) Email address	11) How many hours on average do you work each week?

12) Are you: ☐ Single ☐ Married ☐ In a domestic partnership ☐ Divorced ☐ Legally separated ☐ Widow or widower Date of occurrence:

13) What was your first day of employment?

15) Are you on COBRA or State Continuation? ☐ Yes ☐ No

If yes, provide start date and reason: _____

Section B

Please indicate reason for submitting application. *(Check appropriate box)*

- ☐ New Hire
- ☐ Loss of other coverage
- ☐ Late applicant
- ☐ Rehire
- ☐ Return from layoff
- ☐ Annual open enrollment
- ☐ Part-time to full-time employment or variable-hour employee eligible under ACA
- ☐ Election for continuation or COBRA

Effective date of change: _____

- ☐ Marriage
- ☐ Birth, adoption/placement for adoption
- ☐ Add/delete dependents
- ☐ Name change/address change/PCP change
- ☐ New Employer Group
- ☐ Other

Section C

Please select the type of insurance coverage for which you are applying.

☐ Employee only ☐ Employee and spouse/domestic partner ☐ Employee and dependent child(ren) ☐ Employee, spouse/domestic partner and dependent child(ren)

Name (Last, First Middle)	Relationship to Employee	Social Security Number	Date of Birth	Sex	Disabled Y/N	Height/ Weight	Primary Care Provider or Clinic
	Self						
	Spouse/Domestic partner						
	☐ Child ☐ Stepchild ☐ Grandchild ☐ Other _____						
	☐ Child ☐ Stepchild ☐ Grandchild ☐ Other _____						
	☐ Child ☐ Stepchild ☐ Grandchild ☐ Other _____						
	☐ Child ☐ Stepchild ☐ Grandchild ☐ Other _____						

Section D

Does the dependent child(ren) named within this application live with you at the address shown above? If "no," please list the dependent child(ren)'s name and address(es):

☐ Yes ☐ No

If there is a stipulation in a legal decree or court order stating who is responsible for providing health insurance of the named dependent child(ren), please indicate the name of the person who has primary custody of the dependent child(ren) and the name of the responsible person for health insurance: _____

Do you, your spouse, or your dependent child(ren) listed in this application have current health insurance coverage or had previous health insurance coverage within the last 18 months? ☐ Yes ☐ No **If "yes," please complete the following table:**

Name (Last, First Middle)	Insurance Company, Plan & Group Number	Effective Date of Coverage	Termination Date of Coverage	Reason for Termination of Coverage	Type of Coverage

Section E

I understand that I am eligible to apply for group health insurance through my employer. I do NOT want, and hereby waive, group health insurance for:

☐ Waiving for myself ☐ Waiving for my spouse/domestic partner ☐ Waiving for my dependent child(ren)

☐ Waiving for me, my spouse/domestic partner and my dependent child(ren)

If waiving coverage, please sign below. I understand that if I desire to apply for coverage at a later date I may be considered a late enrollee and not eligible for coverage until the next open enrollment period. I acknowledge this waiting period and elect to decline the coverage because:

☐ My dependent(s) and/or I are already covered by a health benefit plan that provides similar or better coverage.

☐ My dependent(s) and/or I do not wish insurance and are without significant health problems.

☐ My dependent and/or I am not enrolled under the Health Insurance Risk-Sharing Plan (HIRSP) and the annualized premium contribution to be paid by me on behalf of myself or my dependent spouse and child(ren) would exceed 10% of my annualized gross earnings from this employer.

If you are declining enrollment for yourself or your dependents because of other health insurance, you may be able to enroll in this plan if you lose eligibility for the other coverage. Enrollment must be requested within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage).
In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. Enrollment must be requested within 30 days after the marriage, birth, adoption, or placement for adoption.

Employee Signature: _____ Print Name: _____ Date Signed: _____
(Copy/fax valid as original)

Section F

Are you or your spouse or child(ren) covered by Medicare Part A, Medicare Part B, or Medicare Part D? ☐ Yes ☐ No

If "yes," please list name(s): _____

Reason for Medicare: ☐ Age 65 ☐ Disability ☐ End Stage Renal Disease ☐ Disability and ESRD

Part A Effective Date: _____ Part B Effective Date: _____ Part C (Med Advantage) Effective Date: _____ Part D Effective Date: _____

Employee Health History Addendum

		YES	NO
A	Are you, your spouse or any dependent child(ren) currently pregnant or an expectant parent? If "yes," due date is:		
B	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)?		
C	Has anyone named in this application used tobacco or smokeless tobacco during the past 12 months? If "yes," provide information as requested regarding the product, duration and frequency of use.		
D	In the past five 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?		
E	In the last ten years, has anyone named in this application been counseled, consulted or treated for any of the following (please check all conditions that apply):		
E1	Circulatory System including but not limited to: heart disease or disorder, stroke, circulatory disorder, chest pain, high or low blood pressure, elevated cholesterol and/or triglyceride levels, anemia or blood disorder.		
E2	Digestive System including but not limited to: ulcers, stomach disorder, liver disorder, pancreas disorder, gallbladder disorder, intestinal disorder, ulcerative colitis, Crohn's disease, hernia, rectal disorder?		
E3	Genitourinary System including but not limited to: menstrual disorder genital disorder, sexual dysfunction, pregnancy complications (premature birth, miscarriage, c-section), infertility, urinary tract, kidney or bladder disorder or prostate disorder?		
E4	Endocrine System including but not limited to: diabetes, thyroid disorder, adrenal disorder, enlargement of the lymph nodes, connective tissue disorder?		
E5	Ear or Eye System including but not limited to: eye disorder, ear disorder?		
E6	Respiratory System including but not limited to: allergies, asthma, emphysema, sinus or nasal disorder, lung disease or disorder, shortness of breath?		
E7	Nervous System including but not limited to: epilepsy or other seizures, headaches, multiple sclerosis, Parkinson's disease?		
E8	Muscular or Skeletal System including but not limited to: arthritis, fibromyalgia, back disorder, joint disorder, musculoskeletal disorder, skin disorder, chronic fatigue syndrome.		
E9	Cancer including but not limited to: cancer, tumor, abnormal growth, carcinoma in situ?		
E10	Behavioral Health including but not limited to: attention deficit disorder, psychological disorder, suicide attempt, eating disorder?		
E11	Other Conditions including but not limited to: organ or other type of transplant or implant, breast disorder, lupus?		
F	Within the last five years, has anyone named in this application to be covered by this insurance had any other injury, illness or treatment for any conditions 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 recommend to have a test or surgery which was not performed for any reason not already mentioned in this application? We are not seeking the results of HIV antibody test.		
G	If anyone named in this application is taking medication or has had prescribed or recommended any medication during the period of time related to your answer (i.e. past five years, past 10 years or currently taking), please list all those medication, 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 the additional pages)		

If Yes to any questions above, provide details below:

Question #	Name: (yours, spouse's or dependent's)	Condition: Give full details for each question answered "yes," state the condition duration and degree of recovery	Date(s) of Diagnosis & Treatment:	Medication:	Dosage:	Refills per year:	Still Prescribed?	
							YES	NO

If more space is needed, please attach a separate sheet.

Employee Agreement / Authorization to Release Medical Information For Enrollment – SIGNATURE REQUIRED

Terms and Conditions

1. I understand that the previous answers will be relied upon by the Plan Sponsor in the issuance of a Summary Plan Description. **I declare all statements contained in this entire form about me and my dependents are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand that my intentional misrepresentation of a material fact in this application may be used as the basis to rescind, terminate or modify coverage for me or my dependents. Rescind means that the coverage was never in effect.** I agree that no coverage will be effective until the date specified by the Plan Sponsor in the Summary Plan Description. If I am now waiving medical benefits for myself and/or my dependents, I have read the entire Waiver provision, and understand the enrollment requirements if I make request for such benefits at a later date. I authorize my employer to deduct the necessary contribution toward the benefits. I reserve the right to revoke this deduction authorization at any time upon my written notice. Benefits are effective only after approval by the Plan Sponsor or Administrator and satisfaction of any probationary period. Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false information may be found guilty of fraud, which is a crime, in a court of law and may be subject to fines and confinement in prison.

2. I hereby authorize those physicians, medical practitioners, hospital, clinics, veteran's administration facilities, medical information services, urgent care facilities, and other medical or medically related entities, Insurance or reinsurance companies, and consumer reporting agencies that have information available concerning my present or former physical health condition, including drug or alcohol abuse, and/or treatment of me to release any and all such information, including, but not limited to, medical records, health care provider notes, laboratory tests and results, diagnoses, treatment, and prognoses. I understand the information obtained by use of this authorization are to be used for underwriting and risk rating determinations for my employer's self-funded health plan. This authorization is not applicable to psychotherapy notes. I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall be valid for 2 ½ years from the date shown below. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. Should I refuse to sign this authorization, I understand it may affect my enrollment (and my dependents' enrollment) in the benefit plan. All pages must be attached and complete, including this authorization for the application to be considered complete. Incomplete applications may be rejected. If an additional authorization for the release of my (or my dependents') medical records is necessary, I (or my dependents) will be required to sign an authorization for the release of this information prior to enrollment in the plan.

3. I understand that any approved coverage is not effective for me or my dependents if I am not actively at work at my full-time employment with my employer on the assigned effective date, but that such coverage will first become effective on the first day thereafter that I am actively working at such employment.

4. This Application, when approved, and any endorsement, amendment, or rider thereto, will be made part of the contract(s) applied for.

5. No person, except an officer of Dean Health Plan, is authorized to vary or modify a contract. I further understand and agree that Dean Health Plan, its directors, officers, employees, and agents shall not be liable for any injury, damage, or expense (including attorney's fees) that I or any of my dependents suffer as a result of any improper advice, action, or omission on the part of any health care provider.

6. Subject to the acceptance of the Application by Dean Health Plan, I authorize the group, as my remitting agent and until this authorization is revoked in writing, to deduct from my wages or salary a sufficient amount to provide for the regular and timely prepayment of the prevailing subscription fees that are not otherwise contributed by my employer for the contract(s) applied for and to remit the same on my behalf to Dean Health Plan.

7. The contract(s) applied for will become void if and when I cease to be employed or affiliated with the group. Should I wish to retain my membership after such termination, it shall be my responsibility to secure a new application form from Dean Health Plan and to apply for the programs then being offered to such individuals.

The information on this application is valid for a maximum of 90 days from the date of the signature.

I understand and agree upon the terms/conditions listed on this application. A copy of this application is to be considered as valid as the original. I hereby authorize, on behalf of myself and my dependents, Dean Health Plan to obtain or release medical information as set forth on the reverse side of this application. I certify that the plan benefits have been explained to me and/or I am fully aware that benefits may be reduced if I or an insured family member fails to follow any applicable requirements of the plan.

Employee Signature: _____ Date Signed: _____

Dean Health Plan, Inc.
PO Box 56099 • Madison, WI 53705 • 800-279-1301 (TTY: 711) • deancare.com