

- Initial Enrollment  
 Rehire  
 Change to Existing Enrollment\*

**EMPLOYER NAME** \_\_\_\_\_ **Group #** \_\_\_\_\_

**Employee Information (please print, using blue or black ink)**

<b>DATE OF HIRE</b>	<b>LOCATION/DIVISION</b>	<input type="checkbox"/> SALARIED <input type="checkbox"/> HOURLY	<b># OF HOURS WORKED PER WEEK</b>	<b>OCCUPATION/JOB TITLE</b>
Social Security Number	Last Name	First Name	MI	
Mailing Address			Home Phone (include area code)	Work Phone (include area code)
City	State	ZIP Code	Date of Birth:	Gender:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common-law			Height:	Weight:

**Benefit Choices**

<b>Coverage Requested:</b>	<b>Medical Plan Selected</b>	<p><b>COMPLETE THIS SECTION ONLY IF YOU <u>DO NOT</u> WANT COVERAGE</b></p> <p>Waive Coverage for: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)</p> <p>Reason: <input type="checkbox"/> Cost <input type="checkbox"/> Other Coverage (Attach copy of ID card)</p> <p>I understand I (we) will not be able to enroll later unless special enrollment requirements are met or at open enrollment (if available). Pre-existing limitations may apply.</p> <p>(Sign here) _____</p>
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family <input type="checkbox"/> No Medical (please complete waiver section)	<input type="checkbox"/> 1000 80/60 Plan <input type="checkbox"/> 1000 70/50 Plan <input type="checkbox"/> 1500 80/60 Plan <input type="checkbox"/> 1500 70/50 Plan <input type="checkbox"/> 2000 70/50 Plan <input type="checkbox"/> HSA 2650 Plan <input type="checkbox"/> HSA 3250 Plan	

**Change Information (Leave blank if initial enrollment or rehire)\***

<b>ADDITIONS</b>	<b>TERMINATIONS</b>	<b>OTHER CHANGES</b>
<p><b>REASON FOR ADDITION:</b></p> <input type="checkbox"/> Newborn – date of birth _____ <input type="checkbox"/> Adoption – date of placement _____ <input type="checkbox"/> Marriage – date of marriage _____ <input type="checkbox"/> <b>Involuntary</b> loss of other coverage (Proof Required) Date: _____ <input type="checkbox"/> Other (explain) _____ <p><b>COMPLETE DEPENDENT INFORMATION SECTION, BELOW</b></p>	<p><b>REASON FOR TERMINATION:</b></p> <input type="checkbox"/> Divorce or Legal Separation (include ex-spouse's mailing address) _____ <input type="checkbox"/> Dependent child no longer eligible <input type="checkbox"/> Voluntary termination (still eligible) _____ (explain) <input type="checkbox"/> Other (explain) _____ <p><b>Qualifying Event Date:</b> _____  <b>Terminate Coverage for:</b> _____</p>	<input type="checkbox"/> Name Change Former name _____ New name _____ <input type="checkbox"/> Address/Phone # Change <input type="checkbox"/> Other (explain) _____

**Dependent Information (list only those members affected by the requested enrollment or change)**

Mbr	Name (include last name if different)	Relation to Employee	Gender	Date of Birth (MM/DD/YY)	Social Security #	
SP	Height: _____ Weight: _____					<input type="checkbox"/> Spouse by marriage <input type="checkbox"/> Common Law Spouse* (certification may be required)
CH	Height: _____ Weight: _____					<input type="checkbox"/> Financially dependent <input type="checkbox"/> Full-time student
CH	Height: _____ Weight: _____					<input type="checkbox"/> Financially dependent <input type="checkbox"/> Full-time student
CH	Height: _____ Weight: _____					<input type="checkbox"/> Financially dependent <input type="checkbox"/> Full-time student
CH	Height: _____ Weight: _____					<input type="checkbox"/> Financially dependent <input type="checkbox"/> Full-time student

Are you or any of your dependents listed above currently covered under any other medical plan, including Medicare?  No  Yes, please provide the following information:

Member(s) Name(s)	Employer Name	Insurance Company or Employer Name, Address & Phone Number	Policy Number	Medicare A, B or both	Medicare HIC #

PLEASE PROVIDE A CERTIFICATE OF CREDITABLE COVERAGE (HIPAA CERTIFICATE) IF YOU HAVE HAD OTHER GROUP MEDICAL COVERAGE WITHIN THE LAST 12 MONTHS. If there is not proof of prior creditable coverage, pre-existing limitations as defined in the plan document may apply.

I acknowledge receipt of the benefit enrollment materials and certify that, to the best of my knowledge, the information shown on this form is correct and complete. I understand that I may not be able to make changes to these elections except in case of special enrollment or open enrollment (if available).

Employee Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

**For Rocky Mountain Health Plans Use Only**

Effective Date	Location #	Plan #/Coverage/Class	Volumes	ID Card	Adjustment
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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 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?	<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? We are <b>NOT</b> seeking the results of HIV Antibody Test.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
13. Treated by a chiropractor, naturopath, therapist, or acupuncturist?	<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 described)</i>	Date(s) medication taken <i>(indicate if ongoing)</i>	Name and address of prescribing physician or licensed health care provider

## Pre-Existing Condition Limitation Period

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.

- This limitation period shall be no longer than 12 months 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 63 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 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 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 -ode, a public health plan, or a health benefit plan under section 5(e) of the federal "Peace Corps Act" (22 U.S.C. Section 2504(e)).

The insurance company or health plan that provided your previous health care coverage should have given you a certificate stating that you had creditable coverage and specifying the time period of such creditable coverage.

Complete the chart below for yourself and each family member listed on this application. List all current health care coverage policies and/or all previous health care coverage policies in effect during the last 12 months. Add and label additional pages if necessary.

**If you have had insurance coverage in the last 12 months, provide the information requested below.**

List Each Policyholder's Covered Family Member	Name, Address, and Telephone Number of Health Plan or Insurance Company	Effective Date of Coverage
Policyholder's Name: _____ Policy #: _____ Group Name: _____ S.S. Number: _____ Others on policy: _____		From:  To:
Policyholder's Name: _____ Policy #: _____ Group Name: _____ S.S. Number: _____ Others on policy: _____		From:  To:
Policyholder's Name: _____ Policy #: _____ Group Name: _____ S.S. Number: _____ Others on policy: _____		From:  To:

# Signature and Certification

The undersigned, individually and on behalf of the undersigned's dependents ("we"), agree as follows:

I hereby represent that I am an employee of the participating employer and that the statements and answers to the questions on this enrollment form are true and complete to the best of my knowledge and belief. I understand that the statements and answers contained herein will be used by CNIC Health Solutions, Inc., Rocky Mountain HealthCare Options, Inc. and my employer to determine eligibility for coverage under my employer's employee welfare benefits plan (the "Plan") for myself and for persons listed on this enrollment form as my spouse or dependent children. In addition, this information will be used by CNIC Health Solutions, Inc. to administer the Plan, and used by Rocky Mountain Health Care Options, Inc. in connection with stop loss coverage provided to the Plan.

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

I understand that (1) the answers given will be the basis of any coverage provided; (2) coverage, if approved, may be subject to limitations regarding pre-existing conditions as defined by the Plan; (3) any material misrepresentation or failure to provide complete information to questions on this enrollment form may be used as a basis for changing rates or terminating my coverage; (4) if coverage is not approved, I, my spouse and/or dependent children are not entitled to benefits; (5) if I, my spouse and/or dependent children waive coverage and decide to apply for coverage at a later date, evidence of eligibility may be required and enrollment or benefits may be deferred for a specified period of time; and (6) coverage will not be effective until I receive notice that this enrollment form has been approved.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, pharmacy or pharmacy-related entity, pharmacy benefits manager (PBM) or PBM-related entity, consumer reporting agency, insurance or reinsurance company or employer, having information about me or my minor children to provide all such information as may be requested to CNIC Health Solutions, Inc., Rocky Mountain HealthCare Options, Inc. and/or the Plan (consistent with law). This authorization includes any and all information that may be held about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, lab data and EKGs. Although federal regulation requires that you be informed of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received pursuant to this authorization will be protected by federal and state privacy laws and regulations.

I consent to CNIC Health Solutions, Inc. performing case management.

I agree that a copy of this authorization will be valid as an original.

I understand that this authorization is required in order to enable the Plan to make eligibility or enrollment determinations relating to me and/or my dependents or for Rocky Mountain HealthCare Options, Inc.'s underwriting or risk rating determinations for stop loss coverage provided to the Plan. If I refuse to sign or revoke this authorization, the Plan may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying Rocky Mountain HealthCare Options, Inc. in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: 6251 Greenwood Plaza Blvd., Suite 300, Greenwood Village, CO 80111. Such revocation will not be valid if any one of CNIC Health Solutions, Inc., Rocky Mountain HealthCare Options, Inc. or the Plan has taken action in reliance on the authorization.

This authorization expires upon the earliest of the following events: denial of my application, declination of enrollment, or, if covered, when I am no longer covered under the Plan.

The Plan has the right to terminate coverage and deny benefits if any information on this enrollment application, or as otherwise provided by the undersigned to CNIC Health Solutions, Inc., Rocky Mountain HealthCare Options, Inc. and/or the Plan for enrollment purposes, is knowingly false, incomplete, or misleading in any material respect.

Any person who knowingly and with intent to defraud any insurance company or other person submits an enrollment form for coverage or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I understand that the agent submitting this enrollment form represents my interests, not those of CNIC Health Solutions, Inc., Rocky Mountain HealthCare Options, Inc. and/or the Plan. The agent has no right to bind coverage, to alter the terms of coverage or enrollment form in any manner, or to adjust any claim for benefits. I, or my personal representative, have a right to receive a copy of this enrollment form.

All of the foregoing will remain in effect for the entire duration of coverage of the undersigned and the undersigned's dependents under the Plan.

## APPLICANT SIGNATURE

X

Date

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\*This application will expire 90 days from date of signature.

**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.**