GROUP HEALTH PLANS - EMPLOYEE APPLICATION/WAIVER
UNIVERSITY OF THE CUMBERLANDS

❑ **NEW ENROLLMENT** ❑**CHANGE ENROLLMENT**

A. EMPLOYEE INFORMATION

LAST NAME | FIRST NAME | MI

PARTICIPANT SSN: ___ - ___ - ____ PARTICIPANT DOB: __ / __ / __

ADDRESS | CITY | STATE

ZIP CODE

GENDER: ☐ MALE ☐ FEMALE MARITAL STATUS: ☐ MARRIED ☐ SINGLE

HIRE DATE: __ / __ / __ Effective Date: _____

Termination Date: _____

B. COVERAGE YOU ARE REQUESTING

☐ EMPLOYEE ONLY ☐ EMPLOYEE & SPOUSE ☐ EMPLOYEE & CHILD(REN) ☐ EMPLOYEE & FAMILY

IF ENROLLMENT CHANGE PROVIDE QUALIFYING EVENT: _____

C. FAMILY INFORMATION - ENROLLMENT

SPOUSE: LAST NAME | FIRST NAME | MI

SPOUSE SSN: ___ - ___ - ____ SPOUSE DOB: __ / __ / __

GENDER: ☐ MALE ☐ FEMALE

CHILD: LAST NAME | FIRST NAME | MI

CHILD SSN: ___ - ___ - ____ CHILD DOB: __ / __ / __

GENDER: ☐ MALE ☐ FEMALE

CHILD: LAST NAME | FIRST NAME | MI

CHILD SSN: ___ - ___ - ____ CHILD DOB: __ / __ / __

GENDER: ☐ MALE ☐ FEMALE

CHILD: LAST NAME | FIRST NAME | MI

CHILD SSN: ___ - ___ - ____ CHILD DOB: __ / __ / __

GENDER: ☐ MALE ☐ FEMALE

Are you or any of your Dependents covered by **Medicare**? ☐ Yes ☐ No If yes, complete the information on the right	Name	Reason	Covered by:	Dates became effective	Medicare Numbers
		☐ Over 65 ☐ Disabled ☐ End Stage Renal Disease	☐ Part A ☐ Part B ☐ Part C ☐ Part D	A. ____/____/____ B. ____/____/____ C. ____/____/____ D. ____/____/____	A. _____ B. _____ C. _____ D. _____
	Name	Reason	Covered by:	Dates became effective	Medicare Numbers
		☐ Over 65 ☐ Disabled ☐ End Stage Renal Disease	☐ Part A ☐ Part B ☐ Part C ☐ Part D	A. ____/____/____ B. ____/____/____ C. ____/____/____ D. ____/____/____	A. _____ B. _____ C. _____ D. _____

D. PRIOR MEDICAL COVERAGE

1. HAVE YOU OR ANY OF YOUR DEPENDENTS BEEN INSURED THROUGH ANY OTHER PLAN OF HEALTH INSURANCE WITHIN THE PAST SIXTY–THREE (63) DAYS? ☐ **YES** ☐ **NO** **IF YES**, PLEASE COMPLETE THE FOLLOWING REQUIREMENTS:

2. HEALTH INSURANCE COMPANY		TELEPHONE NO.	
POLICY OR CERTIFICATE NO.		EFFECTIVE DATE	
COVERAGE TYPE	☐ INDIVIDUAL ☐ EMPLOYER SPONSORED	TERMINATION DATE	

ATTACH A COPY OF THE CERTIFICATION OF GROUP HEALTH INSURANCE PLAN COVERAGE OR OTHER DOCUMENTATION OF CREDITABLE COVERAGE. This group health plan contains a pre-existing condition exclusion that is limited to a maximum of twelve (12) months. This exclusion period can be reduced by the number of days of your prior creditable coverage and shall be proportionately reduced by the time you were covered under the prior creditable coverage if the prior creditable coverage was in effect at any time during the twelve (12) months before your enrollment date under the Policy. To determine if any pre-existing condition limitation will apply to you, you must present your certificates or certificates of prior creditable coverage. Creditable coverage can include coverage under another group health plan, an individual health policy, short term health plans, student health plans, Medicare, Medicaid, CHAMPUS, a medical health care program of the Indian Health Service or tribal organization, a state health benefits risk pool, any public health plan, or a health plan issued under the Peace Corps Act. You may request a certificate of creditable coverage from a previous employer's insurance company or Health Maintenance Organization (HMO). If you submit a certificate of creditable coverage (or documentation of creditable coverage through other means) then we will make a determination regarding the length of any pre-existing condition exclusion that applies to you or your dependents. We will notify you only if, after considering the evidence, it has been determined the pre-existing condition exclusion period will still be imposed, in full or in part. We reserve the right to modify an initial determination of creditable coverage if we determine that your claimed coverage is in error, provided that we send you a notice of reconsideration.

Premium Payment: I authorize my employer to deduct the requested premium contribution from my earnings.

Authorization to Release Information: I hereby authorize any physician or medical practitioner, hospital, or other organization, institution or person that has any medical records or knowledge of me or my family as to diagnosis, treatment and prognosis regarding any physical, mental, drug or alcohol condition or any and all such information to be given to ARC Administrators or its authorized Administrator or legal representative (including medical review specialists). Any information obtained will not be released by the insurance company except to persons or organizations performing business or legal services in connection with my application or claim, including but not limited to pre-certification of hospital admissions, Continued Stay Review, On-Site Concurrent Review or as may be otherwise lawfully required or as I further authorize. A photocopy of this authorization shall be valid as the original and is valid for thirty (30) months from the date shown below.

U.S. Resident: I understand that the coverage under this plan is available for United States Residents and benefits are not payable for medical expenses outside of the United States except while traveling.

Pre-Existing Conditions: I understand that my coverage and that of my dependents may be subject to pre-existing conditions limitation provisions regardless of the medical conditions disclosed on the application pursuant to the terms of the Group Master Policy.

My Answers Are True and Correct: I have personally reviewed all of my answers to the questions on this application and represent that all of the information I have provided is true and complete. I understand that it is my responsibility to provide truthful, complete and accurate information and I represent I have fully understood all the questions asked. With the exception of health related factors, I understand that my intentional material misstatements or failure to report information may be used as the basis of rescission or termination of coverage for me or my dependents, if any. I understand that under no circumstances is any agent allowed to (a) waive, alter or modify any questions; (b) permit me to inaccurately answer any questions; or (c) instruct me not to disclose any particular medical condition on the application. I understand that no agent is authorized or has authority to alter the terms of the Group Master Policy.

☐ **WAIVER OF COVERAGE.** This is to certify that I have been given an opportunity to insure myself and/or my eligible dependents and I have DECLINED such coverage. I understand that if I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and my dependents in this plan, provided that I request enrollment within thirty-one (31) days of my other coverage ending. In addition, if I have a new dependent as a result of marriage, birth, adoption, party in a suit in which the adoption of child by me is sought or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within thirty-one (31) days after the marriage, birth, adoption, party in a suit in which the adoption of child by me is sought or placement for adoption. If I choose to enroll myself or my dependents, at a later date, for a reason other than the special reasons stated herein, I understand that I and/or my dependents may not enroll until my employer's next enrollment period. I understand that I and/or my dependents will be subject to a twelve (12) month pre-existing conditions limitations period which may be proportionately reduced by my furnishing certification or creditable coverage for myself and/or dependents.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is subject to civil and criminal penalties.

E. SIGNATURE

_____ Date_____

Signature of Employee and Parent if Applicant is under the age eighteen (18) years