

**APPLICATION AND/OR WAIVER OF  
COVERAGE  
FOR GROUP HEALTH INSURANCE**



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**GINA HEALTH STATEMENT DISCLAIMER**

Pursuant to the requirements of the Genetic Information Non-Discrimination Act (GINA), the information being requested in this form is being used only in the process of establishing rates for the person to whom the requested information applies and it is not used for any other purpose or applied to any other individual listed on this application for any purpose.

## Statement of HIPAA Portability Rights

**Pre-existing condition exclusions.** Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "pre-existing condition exclusions." A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a specified period of time before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period. In addition, a pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (in some cases, 18 months if you are a late enrollee). Finally, a pre-existing condition exclusion cannot apply to pregnancy or genetic information and cannot apply to a child who is enrolled in health coverage within 31 days after birth, adoption, or placement for adoption.

If a plan imposes a pre-existing condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Creditable coverage includes: a group health plan, COBRA continuation coverage, health insurance coverage, Medicare, Medicaid, coverage under Title 10, Chapter 55, United States Code (Tricare), Montana Comprehensive Health Association, a health plan offered under Title 5, chapter 89 of the United States Code (Federal Government Plan), State Children's Health Insurance Program (SCHIP), coverage through a high-risk pool in any state, the Peace Corps, a medical program of Indian health service or tribal organization, foreign nationalized healthcare coverage, and a public health plan. If you do not receive a certificate for past coverage, talk to your new plan administrator. You can add up any creditable coverage you have. However, if at any time you went for 63 days from the date the Certificate of Creditable Coverage was issued or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

**Right to get special enrollment in another plan.** Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment according to the Special Enrollment provisions of your plan (usually within 30 or 60 days). (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

**Prohibition against discrimination based on a health factor.** Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

**Right to individual health coverage.** Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a pre-existing condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan;
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

**I ACKNOWLEDGE that I have read the statement of HIPAA Portability Rights.**

**I have prior creditable coverage  Yes  No. If yes, I understand I must submit a certificate of creditable coverage to Allegiance Life & Health Insurance Company, Inc.**



Employee Name: \_\_\_\_\_

## APPLICATION AND/OR WAIVER OF COVERAGE FOR GROUP HEALTH INSURANCE

### Section 1: Eligible Employee Information

Employer Name		Date of Hire	
Last Name	First Name		M/I
Date of Birth (mm/dd/yy)	Social Security Number		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address			
City	State	Zip	Date of Marriage (if applicable)
Home Phone Number	Work Phone Number		Cell Phone Number

### Section 2: Spouse/Dependents - Use additional paper if necessary

Last Name, First Name, & M/I	(required for all enrolling) Social Security Number	Date Of Birth	Gender	Relationship To Employee	Resides with employee?	To Be Covered?
Legal Spouse					Yes / No	Yes / No
Dependent					Yes / No	Yes / No
Dependent					Yes / No	Yes / No
Dependent					Yes / No	Yes / No
Dependent					Yes / No	Yes / No

**Eligible Dependent** means a spouse, an unmarried child under the age of 25 who is either a natural child, stepchild, legally adopted child, or a child placed with the applicant for adoption, and who is not currently enrolled in any other individual health insurance or group health plan, or is eligible for coverage as an employee under a group health plan.

### Section 3: Waiving Coverage

I **decline** to enroll in the health coverage for:  Myself  My spouse  My Dependent Child/Children

**Reason for waiving coverage:**

Other coverage(s) - plan name(s) \_\_\_\_\_

Other reason(s) - (please explain)

I understand that this waiver of coverage may affect the ability of each person listed above to obtain coverage at a later date. Specifically, except during applicable "Special Enrollment Periods", each person listed above may be considered to be a Late Enrollee, and subjected to an exclusionary period for up to eighteen (18) months for any preexisting condition, and that term is defined by Federal Law (HIPAA).

Employee's Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Spouse's Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Employee Name:

**Section 4: Other Health Insurance or Creditable Coverage Information**

**1. Have you or any person applying for coverage on this application had health coverage within the past 63 days?  Yes  No If Yes, please complete the following.**

Company Name		Company Address	
Name of Insured		Effective Date of Coverage	Termination Date of current policy
Dependents Covered (provide names)			
Group/Policy Number		Will this policy replace current policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**2. Is anyone applying for coverage on this application eligible for Medicare?  Yes  No If Yes, complete the following.**

Name		Medicare Eligible - <input type="checkbox"/> Over 65 <input type="checkbox"/> Disability <input type="checkbox"/> Kidney Failure	
Effective Dates	Part A (Hosp)	Part B (Med)	Part D (Rx)
Effective Dates	Part A (Hosp)	Part B (Med)	Part D (Rx)

**3. Have you or anyone applying for coverage on this application received benefits or compensation for an occupational injury, accident, illness, or disease?  Yes  No If Yes, complete the following.**

Is this accident, injury, or illness related to either a -  Workers' Compensation accident  Personal injury accident

Name of person(s)	Date of onset
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Describe the injury, illness, or accident in detail (use additional space on page 7 if necessary)

Is this condition  Ongoing  Resolved – Date of resolution

**Section 5: Medical History (Use additional space on page 6 if needed)**

*You are not required to disclose any information about genetic testing or genetic information relating to you or any blood relative. You are not required to disclose any decision by an insurance company that is based on a genetic test or on genetic information.*

**1. Please list current height and weight for all persons applying for coverage 12 years of age and older.**

Name of Person	Height (ft/in)	Weight (lbs)	Name of Person	Height (ft/in)	Weight (lbs)

**2. Within the last 3 years, have medications (except antibiotics) been prescribed for or been taken by any person applying for coverage?  Yes  No If Yes, please explain**

Name of Person	Name of medication	Condition for which medication was prescribed	Dates (mm/dd/yy)		Provider's Name (First and Last)
			From	To	

Employee Name: \_\_\_\_\_

**3. Has any person to be covered EVER had or been diagnosed with or treated for any of the following?**  
 Yes  No **If Yes, please explain below.**

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>1. <input type="checkbox"/> HIV positive, AIDS or AIDS related complex</li> <li>2. <input type="checkbox"/> Alcohol Abuse</li> <li>3. <input type="checkbox"/> Blood or Coagulation Disorder</li> <li>4. <input type="checkbox"/> Cancer (specify type)</li> <li>5. <input type="checkbox"/> Chemotherapy/Radiation Treatment</li> <li>6. <input type="checkbox"/> Colon or Intestinal Disorder</li> <li>7. <input type="checkbox"/> Chronic Lung Disease</li> <li>8. <input type="checkbox"/> Diabetes</li> <li>9. <input type="checkbox"/> Drug Use</li> <li>10. <input type="checkbox"/> Heart Murmur</li> </ul> | <ul style="list-style-type: none"> <li>11. <input type="checkbox"/> Heart Problems (e.g. blocked arteries, murmur, etc.)</li> <li>12. <input type="checkbox"/> Liver Disease or Disorders</li> <li>13. <input type="checkbox"/> Seizure Disorder/Epilepsy</li> <li>14. <input type="checkbox"/> Severe Mental Disease (e.g. Bi-polar, schizophrenia)</li> <li>15. <input type="checkbox"/> Sleep Apnea</li> <li>16. <input type="checkbox"/> Stroke or Circulatory Problems</li> <li>17. <input type="checkbox"/> Suicide Attempt</li> <li>18. <input type="checkbox"/> Systemic or Discoid Lupus/Connective Tissue Disorder</li> <li>19. <input type="checkbox"/> Tumor (specify type)</li> <li>20. <input type="checkbox"/> Weight Loss Procedure (e.g. Gastric bypass)</li> </ul> |
|--|--|

Condition Number (1-20)	Hospitalized? Yes or No	Name of Person	Diagnosis	Dates (From/To)	Complete Provider/ Facility Name & Address

**4. Has any person to be covered been diagnosed with or treated for any complaint, illness, disorder, or disease related to any of the following in the past 5 years?**  Yes  No **If Yes, please explain below.**

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>21. <input type="checkbox"/> Allergies</li> <li>22. <input type="checkbox"/> Anxiety/Depression</li> <li>23. <input type="checkbox"/> Arthritis (specify type)</li> <li>24. <input type="checkbox"/> Asthma</li> <li>25. <input type="checkbox"/> Attention Deficit Disorder (ADD/ADHD)</li> <li>26. <input type="checkbox"/> Back or Neck Problems</li> <li>27. <input type="checkbox"/> Breasts</li> <li>28. <input type="checkbox"/> Congenital Defects</li> <li>29. <input type="checkbox"/> Counseling (e.g. alcohol, drug, emotional)</li> <li>30. <input type="checkbox"/> Ears (e.g. infections, hearing impairment)</li> <li>31. <input type="checkbox"/> Eating Disorders</li> <li>32. <input type="checkbox"/> Eyes (e.g. crossed eyes, detached retina, cataract, glaucoma)</li> <li>33. <input type="checkbox"/> Fractures (specify type, area of body)</li> <li>34. <input type="checkbox"/> Gastric Reflux (e.g. heartburn)</li> <li>35. <input type="checkbox"/> Headaches / Migraines</li> <li>36. <input type="checkbox"/> Hernia (specify type)</li> </ul> | <ul style="list-style-type: none"> <li>37. <input type="checkbox"/> High Blood Pressure (complete blood pressure chart below)</li> <li>38. <input type="checkbox"/> Infertility/Infertility Treatment</li> <li>39. <input type="checkbox"/> Joints (specify area, left or right if applicable)</li> <li>40. <input type="checkbox"/> Kidneys</li> <li>41. <input type="checkbox"/> Lungs</li> <li>42. <input type="checkbox"/> Nasal/Sinus (e.g. infection, malformation, deviated nasal septum)</li> <li>43. <input type="checkbox"/> Nervous System Disorder</li> <li>44. <input type="checkbox"/> Osteopenia/Osteoporosis</li> <li>45. <input type="checkbox"/> Prostate</li> <li>46. <input type="checkbox"/> Reproductive Organs</li> <li>47. <input type="checkbox"/> Rheumatic Fever</li> <li>48. <input type="checkbox"/> Urinary Tract Infections</li> <li>49. <input type="checkbox"/> Ulcer (specify type)</li> <li>50. <input type="checkbox"/> Thyroid</li> <li>51. <input type="checkbox"/> Other _____</li> </ul> |
|--|--|

*\*\*Please use additional space on Page 6 for complete details of Provider / Facilities if more space is needed.*

Condition Number (21-51)	Hospitalized? Yes or No	Name of Person	Diagnosis	Dates (From/To)	Complete Provider/ Facility Name & Address

**5. Blood Pressure readings must be provided if answered "Yes" to #37 above. (Please give the three most recent readings, at least one month apart.) Use additional paper, if necessary.**

Name of Person	Date Taken	Blood Pressure	Date Taken	Blood Pressure	Date Taken	Blood Pressure

Employee Name:

**6. Has any person applying for coverage received or been recommended to receive any medical treatment that has not been listed as part of this application?** This includes counseling, follow-up for abnormal laboratory studies (including abnormal pap smears), examinations/tests/laboratory studies/x-rays (MRI, CT scan, ECG, ultrasound, mammogram, etc.) or care recommended by physicians, other medical practitioners, or a legal authority.  Yes  No  
**If Yes**, please explain whether the treatment has been received or recommended, and provide date(s), name(s) of person(s), and detailed explanation(s).

**7. Has any person applying for coverage been fitted with any implants or orthopedic device (including pins, screws, plates, or braces) or does any person regularly use durable medical equipment (e.g. wheelchair, splints or crutches, oxygen, CPAP)?**  Yes  No **If Yes**, please provide date(s), name(s), of person(s), and detailed explanation(s). Also note whether orthopedic device(s), is/are temporary or permanent.

**8. Does any family member applying for coverage have reason to believe that she or he is an expectant parent (by positive result of laboratory results, provider test, home pregnancy test, etc.)?**  Yes  No  
**If Yes**, Name of expectant person \_\_\_\_\_ due date \_\_\_\_\_  Single Fetus  
 Multiple Fetus  
**Please explain any signs of complications.**

**9. Is anyone applying for coverage currently in the hospital or other medical or rehabilitation facility?**  
 Yes  No **If Yes**, name of person in facility, facility name and address, duration of stay, and diagnosis for treatment.

**Use blank space below for further information – if necessary.**

Blank space for further information.

Employee Name:
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**Section 6: Employee/Policyholder Information (To Be Completed By Employer)**

Name of Group/Employer	Group Number
Name of Employee	Occupation
Current Number of Hours Worked Per Week	Employee started working the required number of hours to become eligible for coverage on (insert date)
Signature of Group Leader	Date signed
Print Name of Group Leader	

**Section 7: Conditions of Enrollment**

**I/We UNDERSTAND** that providing false, incomplete, inaccurate or incorrect information to any of the questions on the Enrollment Form may be considered insurance fraud and may result in denial or cancellation of coverage from its beginning.

**I HEREBY AUTHORIZE** my employer to make any required payroll deductions for this coverage. I certify that the information provided is true and correct.

This is an application only. No right is given to me or any person listed on this application until Allegiance Life & Health Insurance Company, Inc., accepts me/us and premiums are paid.

I/We personally completed the Medical History section of this form, providing all requested information.

All statements made are true and complete for me and for each person applying for coverage.

Each person applying for coverage is in good health, except for those conditions listed.

I/We understand that waiting periods may apply for pre-existing conditions and/or dental coverage.

Information regarding your insurability will be treated as confidential. Allegiance Life & Health Insurance Company, Inc., or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, Boston, MA 02112, telephone number 617-426-3660.

Allegiance Life & Health Insurance Company, Inc., or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

**I hereby authorize** any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health to give to the Allegiance Life & Health Insurance Company, Inc., or its reinsurers, any such information. A photographic copy of this authorization shall be as valid as the original.

**Section 8: Signature**

**I/We understand and agree that the coverage I/We am/are applying for is subject to the group eligibility and enrollment requirements. I/We have read the Conditions of Enrollment. I/We understand and agree to them.**

You must also have signature(s) of spouse and/or all dependent(s) 18 and over if applying.

Employee Signature	Date
Spouse Signature	Date
Dependent Signature	Date
Dependent Signature	Date
Dependent Signature	Date

Employee Name:



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