Iowa Uniform Group Health Application

Agent No.

Employer Data

Employer _____ Group Number _____ Phone _____

Street Address _____ City _____ State _____ Zip _____ Fax_____

Employee Data

Employee Name _____ Soc Sec Disabled? Y N Medicare Enrolled? Y N Sex: M F

Home Address _____ City _____ State _____ Zip _____

Work Phone # _____ Home Phone # _____ Email_____

DOB_____ Height ____ Weight ____ Social Security #_____ Job Title_____ Date of Hire_____

Primary Care Physician _____

Average Hours Worked per Week _____ Salary/Wage $ _____ Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ COBRA

Marital Status: ☐Married ☐Single ☐Divorced ☐Legally Separated ☐ Widowed ☐ Common Law Marriage (Notarized Affidavit Required)

Coverage Selected

Please indicate which eligible coverage(s) you are choosing:

☐ Medical: ☐Employee ☐Employee/Spouse ☐Employee/Child(ren) ☐ Employee/Spouse/Child(ren)
☐ HMO ☐ PPO ☐ POS ☐ HDHP ☐ Other, define: _____

☐ Dental: ☐Employee ☐Employee/Spouse ☐Employee/Child(ren) ☐ Employee/Spouse/Child(ren)

☐ Life: ☐Employee ☐Employee/Spouse ☐Employee/Child(ren) ☐ Employee/Spouse/Child(ren)

☐Vision ☐Employee ☐Employee/Spouse ☐Employee/Child(ren) ☐ Employee/Spouse/Child(ren)

☐ Disability: ☐Employee/Short Term ☐ Employee/Long Term

Waiver of Coverage

I decline coverage for:

☐Medical ☐Dental
☐Life ☐Vision
☐Disability

Declining coverage due to existence of other coverage:

☐ Spouse's Employer's Plan ☐ Individual Plan ☐ Medicaid
☐ Covered by Medicare ☐ VA Eligibility ☐ Tri-Care
☐ COBRA from prior employer ☐ Other, Explain:_____
☐ I (we) have no other coverage at this time.

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a late enrollee, if applicable. I also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.

Dependent Data

Name (First, MI, Last)	Sex	Height	Weight	Birthdate	Social Security Number	Primary Care Physician	Full-time student?	Medicare enrolled?	Soc. Sec. enrolled?
Spouse	☐M ☐F						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent	☐M ☐F						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent	☐M ☐F						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent	☐M ☐F						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Employee Name _____

Other Coverage

Medicare Coverage: Name _____ ID# _____ Effective Date (Part A) _____ (Part B) _____(Part D) _____			**Previous Coverage:** Within last the 18 months, did you have health insurance coverage? ☐ Yes ☐ No If Yes, please complete the following:		
Concurrent Coverage: Will you, your spouse or your dependents keep other coverage in addition to this coverage? (Check all that apply.) ☐ None ☐ Medical ☐ Dental ☐ Life ☐ Vision ☐ Disability					
Name of covered person(s)			Name of covered person (s)		
Employer (if applicable)			Employer (if applicable)		
Insurance Company/HMO Name and address			Insurance Company Name/Address		
Policy No.	☐ Employee ☐ Employee/Spouse ☐ Employee/Children ☐ Employee/Spouse/Children	Effective Date End Date	Policy No.	☐ Employee ☐ Employee/Spouse ☐ Employee/Children ☐ Employee/Spouse/Children	Effective Date End Date

Reason for Enrollment/Change:
Name of Affected Party _____ Date of Event _____
☐ New Hire ☐ Late Enrollee ☐ Special Enrollee ☐ Loss of Coverage ☐ Marriage ☐ Birth/Adoption ☐ Death ☐ Divorce
☐ Employment Termination ☐ COBRA ☐ Cancel Coverage (reason) _____
☐ Other: _____

Designated Beneficiaries

Group Term Life and/or Voluntary Term Life Beneficiary Designation
(NOTE: The same beneficiary will be used for both Group Term Life and Voluntary Term Life. If you wish to name different beneficiaries for each coverage, please ask your employer for a beneficiary change form to complete in addition to the information shown below).
All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.

Primary Beneficiaries:

Name and Address	*Percentage*	*Relationship*	*Social Security#*

Contingent Beneficiaries:

Name and Address	*Percentage*	*Relationship*	*Social Security#*

The right to make future changes is reserved. If two or more beneficiaries are named, the proceeds shall be paid to the named beneficiaries, or to the survivor or survivors, in equal shares, unless specified otherwise.

If any beneficiary is designated as a trustee, it is understood and agreed that the Plan shall not be a party to nor bound by the conditions of any trust and payment of the net proceeds of said policy on the death of the insured to the then designated beneficiary shall be a complete discharge as to the Plan.

If you have designated a minor child(ren) as your beneficiary, you must complete the Uniform Transfers to Minors Act form.

Employee Name _____

Authorization and Certification

I understand and agree with the following statements with regard to my application for coverage through an insurance Carrier:

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed. I have read and understand the Special Enrollment Rights and know if I refuse medical coverage, I and my dependents must wait for the next open enrollment unless I become eligible during a Special Enrollment. If I refuse dental coverage, I and my dependents may enroll later but this will affect the level of benefits. If I refuse life or disability coverage, I may apply later but I must show proof of good health and coverage will be subject to approval by the Carrier. If I refuse coverage, I cannot enroll after retirement.
- I understand that the coverages applied for will not start until after this application and the appropriate coverage rates are received and accepted by the Carrier and an effective date of coverage is established by the Carrier. I further agree that the Carrier is not liable for a claim before the effective date of coverage and all policy provisions apply. During the first two years coverage for life or disability or medical is in force, false statements, omissions or material misrepresentations can cause changes in that coverage, including cancellation back to the effective date.
- Any person who, with intent to defraud or knowingly is facilitating a fraud against an insurer, submits an application or files a claim with false or deceptive statements, may be guilty of insurance fraud.
- For life and disability coverages, I authorize any health care provider who has personal information, including physical, mental, drug or alcohol use history, regarding me or a dependent, to give such data to the life or disability carrier agents and employees of the Life or Disability Carrier and I authorize the Life or Disability Carrier to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by the Life or Disability Carrier for determining eligibility for life and disability coverage. Information will not be used for any purposes prohibited by law.
- I also understand collection of social security numbers for myself and my dependents will be used by the Carrier only as allowed by law.
- For life coverage, I understand that as the employee, the insurance I and my dependents have applied for will begin on the effective date of coverage provided I am at work on that date. If I am not actively at work on such date, subject to the terms of the group policy, coverage may not go into effect until after my return to work. Furthermore, I understand that no insurance may become effective for any member of my family while he/she is in a period of limited activity.
- For medical coverage, I authorize pharmacy benefit managers, "health care providers", including but not limited to, surgeons, physicians, psychologists, nurses, social workers, health care facilities and other entities covered under the HIPAA Privacy Rule and their agents and employees, to release and disclose my personal health information, including but not limited to, all health & mental records, including those records protected by Federal or State law relating to the diagnosis or treatment of AIDS or AIDS related complex, Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental health and substance abuse, the use of alcohol, drugs, and tobacco, and the past, present, or future treatments or conditions for myself or for my dependents eligible for health care coverage to the Carrier, its agents, and employees, for purposes of underwriting my application for coverage, and making eligibility, premium rating, and enrollment decisions, relating to any coverage I have, have applied for, or may in the future apply for with the Carrier or other entities covered under the HIPAA Privacy Rule. I further understand that the personal health information described above may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws. This authorization shall remain in force for two years following the date of my signature. I may revoke this authorization in writing at any time by sending the request for revocation to the Carrier. I understand that a revocation is not effective until received by the Carrier and that any revocation is not effective to the extent that the Carrier or Providers have relied on the protected health information disclosed to them. This Authorization and Certification does not authorize the redisclosure of medical information except as otherwise stated herein. Federal and State regulations do not allow further disclosure of mental health, substance abuse and AIDS/HIV related information. The Carrier maintains the confidentiality of <u>all</u> information received and it will not be released to any person or facility unless you apply for life and/or disability coverage underwritten by the Life or Disability Carrier in which case the application, <u>without</u> any further health records or Attending Physician Statements (APS) received, will be released to the Life or Disability Carrier. I understand that if I refuse this authorization, the Carrier may not make an eligibility determination, and I will not be considered for coverage with the Carrier.

I hereby authorize the following Carriers, their reinsurers, and their legal representatives to receive, use, and disclose my, my spouse and my dependent child(ren)'s Protected Health Information for the purpose of insurance coverage. I authorize the Carriers to disclose my, my spouse and my dependent child(ren)'s Protected Health Information between themselves, to reinsuring companies, and to the plan administrator or plan sponsor (if other than the employer), insurance intermediaries, or other persons or organizations performing business or legal services in connection with the purpose of insurance coverage: (Either *you or your broker must list all Carriers that are to receive this application for insurance.)*

Carrier _____ Carrier _____ Carrier _____

Carrier _____ Carrier _____ Carrier _____

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I further certify that, after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that the Carrier will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, the Carrier will be entitled to declare any contract or coverage issued pursuant to this application void and to refuse allowance on benefits to any person thereunder, which means that any claims incurred will become my liability. If the group policy does not require my contribution, I understand that I cannot decline any coverage unless the policy indicates otherwise. If the group policy requires my contribution, I authorize my employer to deduct from my pay. I understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from the Carrier.

Print Name _____

Your signature X _____ **Date signed** _____

Discrimination is Against the Law

Medical Associates Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Medical Associates Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Medical Associates Health Plans provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats.

Medical Associates Health Plans provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Member Services at 563-584-4885 or 1-866-821-1365.

If you believe that Medical Associates Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Member Services, Address: 1605 Associates Drive Dubuque, IA 52002, Phone: 563-584-4885 or 1-866-821-1365, TTY: 1-800-735-2942, Fax: 563-584-4760, Email: memberservices@mahealthcare.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Access Services:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-821-1365 (TTY: 1-800-735-2942).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-821-1365 (TTY: 1-800-735-2942)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-821-1365 (TTY: 1-800-735-2942).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-866-821-1365 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-735-2942).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-821-1365 (TTY: 1-800-735-2942).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم1-866-390-3872(رقم هاتف الصم والبكم: 1-800-735-2942).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີ

ພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-866-821-1365 (TTY: 1-800-735-2942).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-821-1365 (TTY: 1-800-735-2942)번으로 전화해 주십시오.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-821-1365 (TTY: 1-800-735-2942) पर कॉल करें।

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-821-1365 (ATS: 1-800-735-2942).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-866-821-1365 (TTY: 1-800-735-2942).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-866-821-1365 (TTY: 1-800-735-2942).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-821-1365 (TTY: 1-800-735-2942).

ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤန့် ကျိာ်အတ်မၤစၢၤလၢ တလာ်ဘူဉ်လာ်စ့ၤ နီတမံၤဘဉ်သ့နူဉ်လီၤ. ကိး 1-866-390-3872 (TTY: 1-800-735-2942).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-821-1365 (телетайп: 1-800-735-2942).