

4. OTHER HEALTH INSURANCE COVERAGE INFORMATION

Are you currently actively at work on a full-time basis? Yes No If no, reason: _____

Are you covered under Employer's current Health Plan? Yes No

If yes, please attach Certificate of Credible Coverage.

Spouse's name: _____ Birth Date _____

Is your spouse employed? Yes No If yes, Employer: _____

Will you or any member of your family be covered under **OTHER** health, medical, dental or vision insurance by divorce decree or any other reason? Yes No If "yes" type of coverage Medical Dental Vision

If yes, who will be covered? 01 Self 02 Spouse 03 Child 04 Child

05 Child 06 Child 07 Child

Note: You must notify SIHO within 30 days of any changes in other insurance coverage.

OTHER Insurance Company Name or Plan (including Medicare Part A, B or both): _____

Applicable only if you or a family member are covered by Other Health Insurance.

Address: _____

5. LIFE INSURANCE INFORMATION (required of all groups under 50 FTE)

You must notify SIHO of any Beneficiary Changes.

Request for Nomination of Beneficiary:

The right is reserved to change the beneficiary hereby designated, without the consent of said beneficiary. If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries (or beneficiary) as survives the insured, unless otherwise provided herein. If no beneficiary survives the insured, settlement will be made in accordance with the terms of the Policy (ies).

| Beneficiary Last Name | Beneficiary First Name | Beneficiary Social Security # | Date of Birth | Relationship | Percent (%) of Benefit |
|-----------------------|------------------------|-------------------------------|---------------|--------------|------------------------|
| PRIMARY | | | | | |
| SECONDARY | | | | | |
| OTHER | | | | | |

6. COMPLETE ONLY IF EMPLOYEE IS DECLINING MEDICAL COVERAGE

If you are choosing **NOT** to enroll, **COMPLETE THIS SECTION.**

If your employer pays 100% of the employee cost of this health care coverage, you must enroll in this Health Plan for the employer to be considered eligible.

WAIVER:

This is to acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through the employer named in Section 3. I hereby waive the health coverage offered. I am waiving the health coverage and declining to enroll because : *(form will be incomplete if selection is not marked)*

I am annually enrolled in:

- Spousal Coverage
 Individual Health Coverage

I have:

- Coverage Under Another Plan
 Medicare, Medicaid, or Medical Supplement Coverage
 Other: _____

(if waiving, you MUST check/complete one of the above)

I attest that I was not pressured nor forced by the employer named in Section 2, the writing agent, SIHO, or any other outside party who might have a vested interest in my waiving (declining) the above noted coverage. I further realize that any future application for coverage under this plan may require additional limitations, waiting periods, or other applicable terms and conditions of a master group contract that would impact my benefits. I also understand that I may be asked to supply additional statements of health for any future enrollment. I freely and voluntarily waive (decline) the above noted coverage.

SIGN ONLY IF DECLINING COVERAGE

Employee Signature: _____ Date: _____

Please make sure Section 1, 2 and 5 are completed if you waive or decline coverage.

7. AGREEMENT AND AUTHORIZATION OF COVERAGE

I acknowledge that I have read the above statements; or they have been read to me, and that I understand them. I declare and agree that the above answers and responses are, to the best of my knowledge and belief, complete, true, and together with any supplement thereto and with no intent to mislead nor deceive, shall be the basis for any certification of coverage and group policy issues. I understand and agree that neither the employer nor any agent has the authority to waive a complete response to any question, pass on coverage or insurability for me or the group, make or alter any contract, or waive any of the rights or requirements of SIHO. I hereby agree that no coverage will be effective until the date specified by SIHO on the certificate of coverage after this enrollment for application has been processed and accepted. I understand that any misrepresentation or omission contained herein relied on by SIHO may impact, reduce, delay or void not only a future claim, but the actual prospective acceptance of the overall risk and/or the employees contract within the contestable period if such misrepresentation or omission affects the acceptance or the evaluation of this risk. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

I agree that any benefit payable on my behalf under my employer's group health plan with SIHO may be paid directly to the provider of care. I authorize my employer to make the necessary deductions from my pay or any disability or retirement annuity benefits to which I may be entitled under any group plan sponsored by my employer which I am enrolled until this authorization is revoked by me in writing. I understand that I must be actively at work full-time on the effective date of coverage or the effective date will be the date I return to work full-time. I also understand that the effective date of coverage for any of my dependents (other than newborn children) may be delayed if that dependent is hospital confined or totally disabled as of the date of their membership enrollment/application form. I understand that, depending upon my certification of creditable coverage, in the event that coverage becomes effective, benefits may not be payable or may be limited for any pre-existing condition (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 by the Enrollee within the 6-month period ending on the effective date of the Enrollee's enrollment in the Health Plan).

Upon signing, I agree to the following terms and conditions for myself and for any eligible dependents if coverage should become effective: I understand that if I (we) make any claim for benefit, or dispute any decision relative to a claim of benefit, it will be resolved according to the group policy. In fact, all benefits and coverage for my eligible dependents and myself will be provided in accordance with that group policy. I agree to abide by the terms and conditions governing membership and the receipt of health services benefits. I understand that I can revoke this authorization at any time by giving written notice to SIHO. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation. If I wish to revoke this authorization, I only need to go back to the requesting entity rather than the data

Group Dental Coverage is provided under the Group Dental Insurance Policy GH-1112-39160 issued to the Employers' Voluntary Benefit Insurance Trust insured by Security Life Insurance Company of America, Minnetonka, MN. Group Vision Coverage is provided under the Group Vision Policy GH-1157 or under the Group Vision Policy GH-1154 issued to the Group Policyholder insured by Security Life Insurance Company of America, Minnetonka, MN.

I understand that unless otherwise required by law, SIHO will provide all required regulatory notices via its website at www.siho.org and to my employee(s). I may also receive a printed copy of regulatory notices upon request.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Unless revoked earlier, this authorization will be valid for thirty (30) months after the date it is signed.

I elect to enroll/apply in the SIHO Medical Health Plan

Signature of Proposed Insured Employee or Personal Representative

Date

Description of Personal Representative