SIHO INSURANCE SERVICES

ASSOCIATION HEALTH PLAN
INSURANCE APPLICATION
EMPLOYEE APPLICATION

SIHO Use Only:
Member ID #: _____
Group ID #: _____ Plan: _____
Network: _____

Please (1) mail this application to SIHO, 417 Washington St., Columbus, IN 47201
Attn: Membership, (2) fax it to (812) 373-8717 or (3) email to membership@siho.org

This application is to be used for group size 1-50 and new hires.

1. REASON FOR APPLICATION

This form is completed in order to officially: ☐ Apply as New Enrollee **EFFECTIVE DATE:** Month _____ Day_____Year _____

I am a: ☐ New Enrollee ☐ Current Enrollee ☐ Special Enrollee ☐ Open Enrollment ☐ Declining Coverage *(Complete sections 2 and 5 only)*

New and Special Enrollees: identify qualifying life event (QLE)? ☐Involuntary Loss of Coverage (*not* failure to pay premium) ☐Divorce ☐Other _____

Date of QLE: ___/___/___ NOTE: If enrolling due to a QLE, proof of QLE (divorce decree, Certificate of Creditable Coverage, Medicaid, etc.) **must** accompany application.

2. PERSONAL INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Social Security #_____ Email Address _____

Home Phone _____ Work Phone _____ Birth Date _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Association _____ Employer _____Location_____

Job Title _____ Date of Full Time Hire _____/____/_____Date of Rehire _____/____/_____

Average Hours Worked: **Working Owners:** ☐ 20+ hrs./wk. or 80+ hrs./mo. **Employees:** ☐ 30+ hrs./wk.

(please mark only one) ☐ Less than 20 hrs./wk. or 80+ hrs./mo. OR ☐ less than 30 hrs./wk. (depending on type of worker)

3. PLAN SELECTION

Please circle your selection from the option(s) offered by your employer:

Products
- **Choice**
- **HSA**

Networks
- **SIHO Norton/Clark**
- **SIHO Baptist Health**
- **SIHO Norton/Clark & Baptist**

Deductible Amounts
- **$2,000**
- **$2,500**
- **$2,700**
- **$3,000**
- **$3,300**
- **$4,000**
- **$5,000**
- **$6,500**

Choose Coverage Type
- **E** Employee Only
- **ES** Employee & Spouse
- **EC** Employee & Children
- **F** Employee & Family

Plan Type
Medical ____

Please complete the table below for each person that will be covered.

	Last Name	First Name	Social Security #	Birth Date	Sex F/M	Primary Care Physician
01 Self						
02 Spouse						
03 Child						
04 Child						
05 Child						
06 Child						
07 Child						

1si ONE SOUTHERN INDIANA
Insurance Under ONE

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

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 any OTHER medical insurance by divorce decree or any other reason?

☐ Yes ☐ No If "yes" type of coverage ☐ Medical

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: _____

Policy # (should be listed on card): _____ Effective Date: _____

5. 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 third-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:** _____

6. WORKING OWNER CERTIFICATION

If applying for coverage on the basis of your status as a Working Owner, please attest that the following information accurately characterizes your circumstances. In the event that any of this information changes, your signature also acknowledges that you have an affirmative obligation to nform both the Association and SIHO about any such changes.

Per relevant Federal laws and regulations, I certify that I qualify as a working owner -- meaning that I specifically:

1) hold an ownership right in the trade/business through which I am applying and that participates in the Association;
2) earns wages/self-employment income from the trade/business as a result of providing personal services to the trade/business; and
3) either:
   - works an average of 20 hrs./week or 80 hrs./month. in providing those personal services to the trade/business; or
   - has wages/self-employment income equal to the shareholder's cost of coverage of the shareholder and his/her beneficiaries

Initial:_____

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 provided as a part of the process of confirming eligibility to participate, or that is not otherwise reasonably corrected upon actual or constructive notice to the undersigned or any participant enrolled hereunder and is 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 to the extent that it authorizes the disclosure of health information other than for health plan purposes.

I agree that any benefit payable on my behalf under the AHP 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 working and otherwise satisfy any applicable eligibility criteria outlined in the Certificate of Coverage.

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 Certificate of Coverage. In fact, all benefits and coverage for my eligible dependents and myself will be provided in accordance with that Certificate. 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 sources and/or providers.

I understand that unless otherwise required by law, SIHO will provide all required regulatory notices via its website at www.siho.org. 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, rescission of coverage, denial of claims 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 above-indicated One Southern Indiana Health Plan Coverage options**

_____ _____

Signature of Proposed Insured Employee or Personal Representative | Date

_____

Description of Personal Representative