

# NEBRASKA UNIFORM GROUP HEALTH APPLICATION

## EMPLOYER DATA

Employer \_\_\_\_\_ Group Number \_\_\_\_\_ Phone \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Fax \_\_\_\_\_

## EMPLOYEE DATA

Employee Name \_\_\_\_\_ Social Security 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

## WAIVER OF COVERAGE

<b>I decline coverage for:</b> <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Vision <input type="checkbox"/> Disability	<b>Declining coverage due to existence of other coverage:</b> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Spouse's Employer's Plan  <input type="checkbox"/> Covered by Medicare  <input type="checkbox"/> COBRA from prior employer  <input type="checkbox"/> I (we) have no other coverage at this time  <input type="checkbox"/> Disability                             </div> <div> <input type="checkbox"/> Individual Plan  <input type="checkbox"/> VA Eligibility  <input type="checkbox"/> Tri-Care  <input type="checkbox"/> Medicaid  <input type="checkbox"/> Other, explain:                             </div> </div>
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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.

Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

## COVERAGE SELECTED

Please indicate your coverage choice - Note: All coverages may not be available from all carriers

	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Employee/Child(ren)	<input type="checkbox"/> Employee/Spouse/Child(ren)
Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Plan selection <input type="checkbox"/> PPO <input type="checkbox"/> HDHP <input type="checkbox"/> Other, define:			
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disability	<input type="checkbox"/> Employee/Short Term	<input type="checkbox"/> Employee/Long Term		

## DEPENDENT DATA

Name (First, MI, Last)	Sex	Height	Weight	Birth date	Social Security Number	Primary Care Physician	Full-Time Student	Medicare Enrolled?	Social Security Enrolled?
Spouse	<input type="checkbox"/> M						<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> F						<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
Dependent	<input type="checkbox"/> M						<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> F						<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
Dependent	<input type="checkbox"/> M						<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> F						<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
Dependent	<input type="checkbox"/> M						<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> F						<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
Dependent	<input type="checkbox"/> M						<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> F						<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No

Agent No: \_\_\_\_\_

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

## OTHER COVERAGE

<b>Medicare Coverage:</b>		<b>Previous Coverage:</b>	
Name: _____ ID#: _____ Effective Date (Part A) _____ (Part B) _____ (Part C) _____		Within the last 18 months, did you have health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please complete the following:	
<b>Concurrent Coverage:</b> Will you, your spouse or your dependents keep other coverage in addition to this coverage? (Check all that apply)  <input type="checkbox"/> None <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Vision <input type="checkbox"/> Disability  Name of covered person(s)  Employer (if applicable)  Insurance Company/HMO Name and Address		Name of covered person(s)  Employer (if applicable)  Insurance Company/HMO Name and Address	
Policy No: _____ <input type="checkbox"/> Employee Effective Date: _____ <input type="checkbox"/> Employee/Spouse End Date: _____ <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Employee/Spouse/Child(ren)		Policy No: _____ <input type="checkbox"/> Employee Effective Date: _____ <input type="checkbox"/> Employee/Spouse End Date: _____ <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Employee/Spouse/Child(ren)	
<b>Reason for Enrollment/Change:</b>			
Name of Affected Party		Date of Event	
<input type="checkbox"/> New Hire <input type="checkbox"/> Late Enrollee <input type="checkbox"/> Special Enrollee <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Employment Termination <input type="checkbox"/> COBRA <input type="checkbox"/> Cancel Coverage (reason)			
<input type="checkbox"/> Other:			

## DESIGNATED BENEFICIARIES

<b>Group Term Life and/or Voluntary Term Life Beneficiary Designation</b> (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). <b>All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.</b>			
<b>Primary Beneficiaries:</b>			
<i>Name and Address</i>	<i>Percentage</i>	<i>Relationship</i>	<i>Social Security #</i>
<b>Contingent Beneficiaries:</b>			
<i>Name and Address</i>	<i>Percentage</i>	<i>Relationship</i>	<i>Social Security #</i>
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 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.			

Agent No: \_\_\_\_\_

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

## HEALTH INFORMATION QUESTIONS

**Please answer each questions fully and accurately. Incomplete answers could delay the processing of your requested coverage.**

## SECTION 1

Please provide the health history of you and any person names in this application who has been diagnosed or treated in the last **10 years** by placing an "X" in the following boxes. **Please further explain your selections in Section 3 - Health Statement Table.**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> 1. AIDS/HIV                             | <input type="checkbox"/> 11. Digestive/Intestinal Disorder                            | <input type="checkbox"/> 21. Liver (cirrhosis, hepatitis B, C, D or E) |
| <input type="checkbox"/> 2. Allergy/Asthma                       | <input type="checkbox"/> 12. Drug or Alcohol Abuse                                    | <input type="checkbox"/> 22. Mental or Nervous Disorder                |
| <input type="checkbox"/> 3. Arthritis                            | <input type="checkbox"/> 13. Eating Disorder  | <input type="checkbox"/> 23. Migraine Headaches                        |
| <input type="checkbox"/> 4. Bladder/Urinary Disorder             | <input type="checkbox"/> 14. Endocrine/Pancreatic Disorder                            | <input type="checkbox"/> 24. Neck, Back or Spine Disorder              |
| <input type="checkbox"/> 5. Blood, Bleeding or Clotting Disorder | <input type="checkbox"/> 15. Eye, Ear, Nose or Throat Disorder<br>(excluding glasses) | <input type="checkbox"/> 25. Organ Transplant                          |
| <input type="checkbox"/> 6. Bone/Joint/Muscular Disorder         | <input type="checkbox"/> 16. Heart/Circulatory Disorder                               | <input type="checkbox"/> 26. Respiratory/Lung Disorder                 |
| <input type="checkbox"/> 7. Cancer                               | <input type="checkbox"/> 17. High Blood Pressure                                      | <input type="checkbox"/> 27. Skin Disorder                             |
| <input type="checkbox"/> 8. Cyst                                 | <input type="checkbox"/> 18. High Cholesterol   | <input type="checkbox"/> 28. Stroke/Nervous System/Brain Disorder      |
| <input type="checkbox"/> 9. Current Pregnancy: Due Date_____     | <input type="checkbox"/> 19. Infertility  | <input type="checkbox"/> 29. Tumor                                     |
| <input type="checkbox"/> 10. Diabetes                            | <input type="checkbox"/> 20. Kidney Disorder (dialysis or failure)                    | <input type="checkbox"/> 30. Tobacco Product Use                       |
|  |   | <input type="checkbox"/> 31. Vascular (blood vessel) Disorder          |

## SECTION 2

Please answer yes or no to the following questions. **Please further explain your "Yes" selections in Section 3 - Health Statement Table.**

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 32. Have you or any person named in this application received inpatient or outpatient services in the last three (3) years (excluding routine tests, physicals or inoculations)? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 33. Do you or any person named in this application have tests, treatments, hospitalization or surgery planned or recommended in the future?                                      |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 34. Do you or any person named in this application take any medicine, prescription drugs or require shots/injections?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 35. Do you or any person named in this application have any other medical conditions which have not yet been previously mentioned?   |

### SECTION 3 Health Statement Table

For any of the "X" or "Yes" responses provided in SECTION 1 and 2 questions above, please provide full details in the following table per Question Number (Q#). If you need additional space, please attach another sheet. (An additional sheet must include your signature and the date on it as verification that the information is yours).

[illegible]

Agent No: \_\_\_\_\_

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 Pre-Existing Condition Exclusion and 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 coverage 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 and 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 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 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 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 all 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, without 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 purposes 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, 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 \_\_\_\_\_

Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

**Waiver - Detail**  
**OCI Insurance and Financial Services**

I decline Medical coverage for the following: \_\_\_\_\_

Declining coverage due to:

Spouse's Employer's Plan  
Covered by Medicare  
COBRA from prior employer  
I (we) have no other coverage at this time

Individual Plan  
VA Eligibility Tri-Care  
Medicaid  
Other, explain: \_\_\_\_\_

I decline Dental coverage for the following: \_\_\_\_\_

Declining coverage due to:

Spouse's Employer's Plan  
Covered by Medicare  
COBRA from prior employer  
I (we) have no other coverage at this time

Individual Plan  
VA Eligibility Tri-Care  
Medicaid  
Other, explain: \_\_\_\_\_

I decline Life coverage for the following: \_\_\_\_\_

Declining coverage due to:

Spouse's Employer's Plan  
Covered by Medicare  
COBRA from prior employer  
I (we) have no other coverage at this time

Individual Plan  
VA Eligibility Tri-Care  
Medicaid  
Other, explain: \_\_\_\_\_

I decline Vision coverage for the following: \_\_\_\_\_

Declining coverage due to:

Spouse's Employer's Plan  
Covered by Medicare  
COBRA from prior employer  
I (we) have no other coverage at this time

Individual Plan  
VA Eligibility Tri-Care  
Medicaid  
Other, explain: \_\_\_\_\_

\_\_\_\_\_  
applicant

\_\_\_\_\_  
date