Division of Insurance

COLORADO UNIFORM EMPLOYEE APPLICATION FOR SMALL GROUP HEALTH BENEFIT PLANS

This form is designed for an employee's initial application for coverage. Please contact your agent or the carrier to determine if this form should be used in other situations once the group is enrolled with the carrier.

COVERAGE INFORMATION

Application Type:	☐ New Coverage	☐ Change/Modification to Existing Policy	☐ Open Enrollment	☐ Special Enrollment*

* Proof of eligibility for special enrollment will be required – information on eligibility for special enrollment periods is available at: www.dora.colorado.gov/DOI/HealthApp

EMPLOYER INFORMATION

Employee Name:		**Employer Name:**	
Proposed Effective Date:		**Group Number (if known):**	

EMPLOYEE INFORMATION

Employee Instructions: Please type or print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought.

First Name:		Middle Initial:		Last Name:	
Social Security #:		Date of Birth:	/ /	Current Age:	Sex: ☐ M ☐ F
Address:				City:	
County:		State:		Zip:	
Mailing Address (If different):				City:	
County:		State:		Zip:	
Home Phone:		Email:		☐ Home	☐ Work
What is your job title at your current employer?				Work Phone:	
What was your first day of employment?		How many hours, on average, do you work each week?			

Are you (check one):	☐ Single	☐ Married	☐ Common Law*	☐ Civil Union*
	☐ Designated Beneficiary*	☐ Legally Separated	☐ Divorced	☐ Widow or Widower

* A common law, civil union, or designated beneficiary certification may be required by the carrier

Are you on COBRA or State Continuation?	☐ Yes	☐ No	Start Date:		Stop Date:

TYPE OF HEALTH COVERAGE

List all dependents (spouse/partner and child(ren)) applying for coverage. **If you need additional space, please use a separate sheet of paper and attach it to this application (please print your name and sign and date the additional sheet).**

Please select the type of health insurance coverage for which you are applying: ☐ Employee Only ☐ Employee & Family

DEPENDENT INFORMATION
(list all dependents to be covered)

Name (First, MI, Last)	Sex	Social Security Number	Relationship	Disabled	Birth Date (MM/DD/YY)
	☐ M ☐ F		SPOUSE/PARTNER		
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	

Employee Name:	Employer Name:

TOBACCO USE

Please answer the following questions to the best of your knowledge. 45 CFR 147.102(a)(1)(iv) "For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used."

Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months? If yes, provide the information requested below.

Name of Person	Used Tobacco Products	If Yes, check all that apply	Duration	Frequency
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		

EMPLOYEE/DEPENDENT WAIVER OF COVERAGE

Complete this section ONLY if you are not enrolling yourself or your spouse/partner or dependents. Waiver must be completed for all of your dependents to be eligible for enrollment on this plan in the event of changing circumstances. I understand that I am eligible to apply for group health coverage through my employer. I do **NOT** want, and hereby waive, group health coverage for:

	Name (Last, First, MI)	Birth Date (Mo/Day/Year)
Employee		
Spouse/Partner		
Dependent 1		
Dependent 2		
Dependent 3		

I am **waiving** group health coverage for myself and/or the dependents listed above because (check all that apply, **copy of ID card may be required**):

- ☐ I am covered under my spouse/partner's group policy.
- ☐ My spouse/partner is covered under another plan (including this plan, if spouse/partner is also an employee).
- ☐ My dependents are covered under another plan.
- ☐ I wish to continue other coverage obtained through an Individual Plan or Medicare
- ☐ Other (Please explain): _____

WAIVER: I certify that I have been given the opportunity to apply for group health coverage and decline to enroll as indicated above, on behalf of myself, my spouse/partner and my dependent child(ren). I understand that by signing this waiver, I, my spouse/partner, and my dependent child(ren) forfeit the right to coverage. I was not pressured, forced or unfairly induced by my employer, the agent or the carrier(s) into waiving or declining the group health coverage. If in the future I apply for coverage, I, my spouse/partner, or any of my dependent child(ren) may be treated as a late enrollee and subject to postponement of coverage for up to 12 months.

I understand that if I am declining enrollment for myself, my spouse/partner, or my dependent child(ren) because of other health coverage, I may, in the future, be able to enroll myself, my spouse/partner, or my dependent child(ren) in this plan, as required by law, provided that I request enrollment within 30 days after my other health coverage ends or a qualifying event occurs. **If I do not request enrollment within 30 days of the above events, I understand that I may not be able to enroll for coverage until my company's Open Enrollment period. I understand that I can obtain information related to my enrollment eligibility from my employer or small group health carrier.**

Signature of Employee: **Date Signed:**

Employee Name:	Employer Name:

MEDICARE INFORMATION

If you need to complete this section for more than one person, please use a separate sheet of paper and attach it to this application (please sign and date the additional sheet). A copy of your ID card may be required.

Are you, your spouse/partner or your child(ren) covered by:

Medicare Part A? ☐Yes ☐No Medicare Part B? ☐Yes ☐No Medicare Part D? ☐Yes ☐No

If "Yes," reason for Medicare: ☐ 65+ Eff. Date_____ ☐Disability Eff. Date_____

☐ End-Stage Renal Disease (ESRD) Eff. Date_____ ☐ Disability and ESRD Eff. Date_____

Name of person covered by Medicare:

CURRENT MEDICAL COVERAGE

Do you, your spouse/partner, or your dependent child(ren) listed in this application currently have health insurance coverage? ☐ Yes ☐No

Is the plan information listed below the same for your spouse/partner and all dependents? If yes, skip to next section. ☐ Yes ☐No

Your information will help the small employer carrier(s) to coordinate benefits with any other group health coverage you may have.

Name	Carrier Name Carrier Phone Number	Plan Name Group Number Subscriber ID#	Effective Date of Coverage (MM/DD/YY)	Termination Date of Coverage (MM/DD/YY)	Type of Coverage (See Key Below)

Type of Coverage Key: G = Group Comprehensive Major Medical; I = Individual Comprehensive Major Medical; MS = Medicare Supplement; H = Hospital Coverage Only; V = Vision Coverage Only O=Other, please explain:_____

HEALTH PROVIDER OR PRODUCT SELECTION, IF APPLICABLE

Please select the type of coverage for which you are applying from the plans offered by your employer and issued by the carrier. This section should be completed only if the small employer group insurance for which you are applying requires the selection of a primary care provider. A selection should be made for each individual applying for such coverage and for each carrier from which insurance coverage is being sought. The provider information may be listed in the provider materials that are supplied by each carrier to your employer. Use additional sheets if necessary.

Covered Person's Name	Medical Plan	Primary Care Physician Name:	Primary Care Physician Address: (optional)	Is this your current provider?

Employee Name:	Employer Name:

TERMS AND CONDITIONS

I acknowledge that I have read all sections of this Colorado Uniform Employee Application for Small Employer Group Health Coverage (Application), and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge. I understand and agree that neither my employer nor any insurance agents have any authority to waive my complete answer to any question, agree to insurability, alter any contract, or waive any Colorado small employer carrier's other rights or requirements.

I hereby apply for enrollment for myself and for my eligible family dependents listed. On behalf of my eligible family dependents and myself, I agree to all of the terms and conditions of the group contract(s) with Colorado small employer carrier(s) under which I wish to enroll for coverage. I have indicated in this Application, if required, what product(s) or provider(s) I have selected. **I agree that no coverage will be effective until the date specified by the Colorado small employer carrier(s) with whom I enroll, after this application has been accepted by such carrier(s)**.

I understand and agree that any information obtained in connection with this Application will be used by Colorado small employer carrier(s) to determine eligibility for coverage.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

When applicable, I authorize my employer to deduct contributions from my earnings to be applied to the cost of coverage.

I agree to any applicable group contract provisions for the resolution of disagreements and disputes, including arbitration when required and as allowed by law. Please refer to any arbitration provisions in the group contract(s).

I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document will become a part of the contract when coverage is approved and issued.

Signature of Employee: _____ **Date Signed:** _____

DISCLOSURES

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY APPLICABLE HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO ANY SMALL EMPLOYER THAT APPLIES FOR THE PLAN AND AGREES TO MAKE THE REQUIRED PREMIUM PAYMENTS, AND SATISFIES THE OTHER PROVISIONS OF THE HEALTH BENEFIT PLAN.

This document is a publication of the Colorado Division of Insurance. If you have questions about the content of this document please contact our offices at 303-894-7499 or visit our website at http://dora.colorado.gov/insurance. For questions regarding coverage or enrollment please see your employer.

Employee Name:	Employer Name:

This page may be used to provide additional information that was required in the sections above and did not fit in the space provided.

Signature of Employee: _____ Date Signed: _____