

2019 Employee Health Application

SECTION 1: EMPLOYER INFORMATION								
Employer Name:								
Employer Name.								
Street Address		1	City				State	Zip
SECTION 2: EMPLOYEE INFORMATION	l							
Employee Full Name (Last name – First name – Mi		Hire Date (Required in Enrolling)			rolling)	Birth Date (mm/dd/yyyy)		
Street Address			City				State	Zip
Employee Social Security # (Required in Enrolling)							acco Use Yes	
Marital Status: Single	☐ Divorced ☐ Mai	ried	Wido	owed				
Home Phone	Cell Phone				Email Addı	ress		
Job Title	Job Title Hours Worked Per Week (Required in Enrolling)							
Spouse's Employer		:	Spouse'	's Bus	iness Phone			
SECTION 3: OTHER INSURANCE COVE	RAGE							
Are you or any dependent(s) disabled? [If Yes, please indicate name(s):								
Do you, your spouse or dependents have other health insurance coverage that will continue in addition to this coverage? Yes No If Yes, name of Carrier:								
Policy Holder's Name:			olicy#			Effective Date		
Name(s) of Covered Dependents:		•						
Section 4: DEPENDENT INFORMATION	(Please complete for all particip	oating depend	lents. Att	ach ad	lditional sheet	s if nece	ssary)	
First Name Last Name	Relationship (Spouse, Son, Daughter)	Social Securi (Required if Enroll		DOB (mm/de	d/yyyy)	Age	M/F	Tobacco Use YES / NO
SECTION 5: HEALTH PLAN PARTICIPATION								
☐ I elect coverage Coverage Level (Choose) ☐ I decline coverage ☐ Employee Only					Plan Desig Options pr			erwriting
					approval	oviaca	apon ana	CIWITCHIS
Employee / Spouse					арргочаг			
	en							
Family								
Reason for Decline:								
Spouse's Employer's Plan Individual Plan Medicare Medicaid COBRA from Prior Employer VA Eligibility I (we) have no other coverage at this time Other:					iii Prior Employer			
│ VA Eligibility ☐ I (we)	have no other coverage at t	.ms urne		ner:				

SECTION 6: HEALTH INFORMATION (Please furnish us with the height and weight for you and your spouse)									
Sel	f: Height	feet inche	es; WeightIbs.	Spouse: Height	_ feet in	ches; Weight	lbs.		
Ple	Please answer the following health questions regarding any medical conditions or medical treatment for you and your family.								
1.	1. Have you or any of your dependent(s) been diagnosed or treated for, or has hospitalization or surgery not yet performed been recommended for, any of the following conditions in the past five (5) years? If so, the plan requires you to disclose these conditions solely for underwriting purposes (and you can properly disclose by checking "Yes" for each of the conditions for which you and/or your dependents have previously received diagnosis, treatment or a recommendation for hospitalization or surgery not yet performed). Although neither you nor your dependents will be denied coverage because of any previous treatment, diagnosis or recommendation for hospitalization or surgery not yet performed for any condition, if you fail to disclose any previous treatment, diagnosis, recommendation								
	of hospita	alization or surgery not y	vet performed for a condition lister geries or hospitalizations for that	ed below, the health plai	n will not cover ar	ny medical expenses,	diagnosis,		
	as part of	this application. NOTE:	You are required to disclose any update	es to these health questions to	hat may arise prior t	o the effective date of yo	our coverage.		
		iac Disorder	☐ Yes ☐ No ☐ Yes ☐ No	I Alcohol / Drug J Mental / Nervo		∐ Yes □ Yes	∐ No □ No		
	C Diabe	er / Tumor (any form) etes	Yes No	J Mental / Nervo		☐ Yes	□ No		
		ey Disorder	☐ Yes ☐ No	L Stomach / Gast		Yes	☐ No		
	-	iratory Disorder	☐ Yes ☐ No		Bone, Joint Disorde		☐ No		
	_	Disorder	☐ Yes ☐ No ☐ Yes ☐ No	•	ulsions, Epilepsy	Yes	□ No □ No		
		Blood Pressure / HIV / Immune System Dis	= 1.11 = 1.11	O Any Other Med	lical Condition (not li	isted above)	∐ No		
2.		ne past 5 years, have you otherwise modified?	or any dependent ever had an a	application for insurance	declined, postpo	oned, Nes	☐ No		
3.	Have you or any of your dependent(s) had any medical conditions in the past 24 months requiring medical care, prescription management, surgery, or hospitalization?								
*	If Yes, ple	ease provide information	n on who and for what condition	s in space provided belo	w				
4.									
·	* If Yes, please provide information on who and for what medical conditions in space provided below								
5.	5. Are you or any of your dependent(s) anticipating hospitalization or surgery, or had surgery or hospitalization Yes No recommended that has not been performed?								
*									
6.	Are you or any dependent(s) currently pregnant or suspect you / they may be pregnant?								
*	* If Yes, please provide due date and detail in space provided below								
	If you answer "Yes" to any of the questions above, please provide detail in space provided below.								
7.	Question Number	Family Member	Disease / Diagnosis / Treatme	Date of Onset Month / Year	Date Last Seen By Physician	Remaining Symp			

(As Necessary, Please Attach Additional Sheets, Signed and Dated by the Employee Subscriber.)

8.	Prescriptions / Medications – List any medications, prescriptions, or injections taken in the last 12 months						
	Family Member Name	Medication / Rx / Injection	Dosage	Medical Condition			

(As Necessary, Please Attach Additional Sheets, Signed and Dated by the Employee Subscriber.)

SECTION 7: AGREEMENTS, AUTHORIZATION & ATTESTATION

Agreements

The answers and statements on this Employee Health Application are true and complete. I agree that they shall form a part of the contract of insurance under which I am applying for coverage. I understand and agree that the insurance applied for shall not take effect until approved by the insurance carrier at its home office. I have read, or have had read to me, the completed application and I realize that any false statements or misrepresentation in the application may result in loss of coverage under the contract. I agree to disclose any updates to the answers and statements on this Employee Health Application that may arise prior to the effective date of my coverage.

Fraud Warning

Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

Medical Authorization

I hereby authorize my health plan, healthcare provider, and their applicable business associates to disclose my Protected Health Information ("PHI") to Medova Healthcare Financial Group, LLC and Medova's respective carriers. I authorize Medova Healthcare and Medova's respective carriers to assist me in obtaining health care services, payment information, or account resolution. Medova Healthcare and Medova's respective carriers will not use this information for any purposes other than underwriting, eligibility, precertification and authorization, utilization management, case management, disease management, and patient advocacy services. PHI includes the following: enrollment, claims, payment, or managed-care information.

Unless otherwise revoked in writing, this authorization will commence on the date indicated below and will expire twenty-four months from the date below. I understand that:

- Information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 C.F.R. Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 C.F.R. Part 164), and the Privacy Act of 1974 (5 U.S.C. § 552a).
- I may revoke the authorization at any time by giving written notice of the revocation to Medova Healthcare Financial Group, LLC at 345 N. Riverview, Suite 600, Wichita, KS 67203. Revocation of this authorization will not affect any action that Medova Healthcare, Medova's respective carriers, or any duly authorized representatives, have taken reliance on this authorization before my written notice of revocation was received.
- Medova Healthcare Financial Group LLC provides administrative and informational services for our respective carriers only and does not provide health insurance or medical services, nor does either recommend or endorse any treatment.

Acknowledgement & Attestation

In the event that I enroll in a Lifestyle Health Plan, I understand that the aforementioned authorization will remain in force as it relates to the normal functions and duties of Medova Healthcare in conducting its administrative, care coordination, member services, and population health duties and responsibilities. I also hereby agree to abide by the terms and conditions of the summary plan documents which consist of the employee benefit booklet and schedule of benefits and contain the benefits, limitations, and exclusions applicable to my health and other benefit coverage. I hereby acknowledge that I may obtain a copy of these documents from my employer directly. I hereby consent to receive (i) from my employer, an electronic version of the Summary Plan Documents, Summary of Benefits and Coverage, HIPAA Portability Notice, HIPAA Privacy Notice, and other DOL, HHS, or IRS required participant notices and summaries and (ii) from Medova Healthcare, an electronic version of my claims information, including explanation of benefits (EOBs), all of which will be available to me on the online web portal. I understand that I can request a paper copy of these documents, update my contact information, and/or withdraw this authorization at any time (all without charge) by contacting Medova (with respect to EOBs and other claims information) or my employer directly (with respect to all other disclosures listed above). Upon request, a customer service representative can explain my benefit coverage options. I have read and understand the above conditions and declarations.

Employee Signature:	 Date:	
3 P a g e		