



2019 Employee Health Application

SECTION 1: EMPLOYER INFORMATION

Employer Name:			
Street Address	City	State	Zip

SECTION 2: EMPLOYEE INFORMATION

Employee Full Name (Last name - First name - Middle name)		Hire Date (Required in Enrolling)	Birth Date (mm/dd/yyyy)	
Street Address		City	State	Zip
Employee Social Security # (Required in Enrolling)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Tobacco Use <input type="checkbox"/> Yes <input type="checkbox"/> No	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed				
Home Phone		Cell Phone	Email Address	
Job Title		Hours Worked Per Week (Required in Enrolling)		
Spouse's Employer			Spouse's Business Phone	

SECTION 3: OTHER INSURANCE COVERAGE

Are you or any dependent(s) <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please indicate name(s):	
Do you, your spouse or dependents have other health insurance coverage that will continue in <input type="checkbox"/> Medicare <input type="checkbox"/> this coverage? If Yes, name of Carrier:	
Policy Holder's Name:	Policy #
Effective Date	
Name(s) of Covered Dependents:	

Section 4: DEPENDENT INFORMATION

Please complete for all participating dependents. Attach additional sheets if necessary)

First Name	Last Name	Relationship (Spouse, Son, Daughter)	Social Security # (Required if Enrolling)	DOB (mm/dd/yyyy)	Age	M / F	Tobacco Use YES / NO

SECTION 5: HEALTH PLAN PARTICIPATION

<input type="checkbox"/> I elect coverage <input type="checkbox"/> I decline coverage	Coverage Level (Choose) <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee / Spouse <input type="checkbox"/> Employee / Children <input type="checkbox"/> Family	Plan Design Selected Options provided upon underwriting approval
Reason for Decline: <input type="checkbox"/> Spouse's Employer's plan <input type="checkbox"/> Individual Plan <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> COBRA from Prior Employer <input type="checkbox"/> VA Eligibility <input type="checkbox"/> I (we) have no other coverage at <input type="checkbox"/> Other:		

Information (Please furnish us with the height and weight for you and your spouse)

Spouse: Height ____ feet ____ inches; Weight ____

Please answer the following health questions regarding any medical conditions or medical treatment

- 1. Have you or any of your dependent(s) been diagnosed or treated for, or has hospitalization or surgery recommended for, any of the following conditions in the past five (5) years? If so, the plan requires you to disclose this information for underwriting purposes (and you can properly disclose by checking "Yes" for each of the conditions if your dependents have previously received diagnosis, treatment or a recommendation for hospitalization or surgery). Although neither you nor your dependents will be denied coverage because of any previous treatment, diagnosis, hospitalization or surgery not yet performed for any condition, if you fail to disclose any previous treatment, diagnosis, hospitalization or surgery not yet performed for a condition listed below, the health plan will not cover any treatment, services, supplies, surgeries or hospitalizations for that undisclosed condition related or attributable to that condition. You are required to disclose any updates to these health questions that may arise prior to the effective date of this application.**

A	Cardiac Disorder	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	I	Alcohol / Drug Abuse	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
B	Cancer / Tumor (any form)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	J	Mental / Nervous Disorder	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
C	Diabetes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	K	Neuromuscular Disorder	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
D	Kidney Disorder	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	L	Stomach / Gastrointestinal	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
E	Respiratory Disorder	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	M	Arthritis, Back, Bone, Joint Disorders	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
F	Liver Disorder	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	N	Seizures, Convulsions, Epilepsy	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
G	High Blood Pressure	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	O	Any Other Medical Condition mentioned above	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
H	AIDS / HIV / Immune System Disorders	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No						

2. Within the past 5 years, have you or any dependent ever had an application for insurance declined, postponed or otherwise modified? ☐ Yes ☐ No

- | | | | |
|----|---|------------------------------|-----------------------------|
| 3. | Have you or any of your dependent(s) had any medical conditions in the past 24 months requiring medical prescription management, surgery, or hospitalization? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|----|---|------------------------------|-----------------------------|

* If Yes, please provide information on who and for what conditions in space provided below

4. In the past 24 months, have you or any of your dependent(s) had more than \$5,000 ☐ medical expenses?

* If Yes, please provide information on who and for what medical conditions in space provided below

5. Are you or any of your dependent(s) anticipating hospitalization or surgery, or had surgery or hospitalization recommended that has not been performed? ☐ Yes ☐ No

*** If Yes, please provide information below**

6. Are you or any dependent(s) currently pregnant or suspect you / they may be pregnant? ☒ Yes ☐ No

* 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

[illegible]

(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 which I am applying for coverage. I understand and agree that the insurance applied for shall not take effect until approved by the insurance 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 will result in loss of coverage under the contract. I agree to disclose any updates to the answers and statements on this Employee Health Application as they occur from 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 to Medova Healthcare Financial Group, LLC and Medova’s respective carriers. I authorize Medova Healthcare and Medova’s respective carriers to use this information for health care services, payment information, or account resolution. Medova Healthcare and Medova’s respective carriers will not use this information for purposes other than underwriting, eligibility, precertification and authorization, utilization management, case management, disease management, or 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 of execution. 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 release to the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 C.F.R. Part 164.504) of 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, Suite 600, Wichita, KS 67203. Revocation of this authorization will not affect any action that Medova Healthcare, Medova’s respective carriers, or their 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 rights and duties of Medova Healthcare in conducting its administrative, care coordination, member services, and population health duties and I hereby agree to abide by the terms and conditions of the summary plan documents which consist of the employee benefit booklet and summary plan documents contain the benefits, limitations, and exclusions applicable to my health and other benefit coverage. I hereby acknowledge that I may obtain copies of these documents from my employer directly. I hereby consent to receive (i) from my employer, an electronic version of the Summary Plan Documents, including 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 through a web portal. I understand that I can request a paper copy of these documents, update my contact information, and/or withdraw this authorization (all without charge) by contacting Medova (with respect to EOBs and other claims information) or my employer directly (with respect to a summary plan document listed above). Upon request, a customer service representative can explain my benefit coverage options. I have read and understand the terms of these declarations.

Employee Signature: _____ Date: _____