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** ☐ Male ☐ Female	**Tobacco Use** ☐ Yes ☐ No	
Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ 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) covered by ☐ **Yes** ☐ **No**
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:	**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

☐ **I elect coverage** ☐ **I decline coverage**	**Coverage Level (Choose)** ☐ **Employee Only** ☐ **Employee / Spouse** ☐ **Employee / Children** ☐ **Family**	**Plan Design Selected** **Options provided upon underwriting approval**

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:**

SECTION 6: HEALTH INFORMATION (Please furnish us with the height and weight for you and your spouse)

Self: Height ___ feet _____ inches; Weight _____ Spouse: Height ___ feet _____ inches; Weight _____

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

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

A	Cardiac Disorder	☐ Yes	☐ No	I	Alcohol / Drug Abuse	☐ Yes	☐ No
B	Cancer / Tumor (any form)	☐ Yes	☐ No	J	Mental / Nervous Disorder	☐ Yes	☐ No
C	Diabetes	☐ Yes	☐ No	K	Neuromuscular Disorder	☐ Yes	☐ No
D	Kidney Disorder	☐ Yes	☐ No	L	Stomach / Gastrointestinal	☐ Yes	☐ No
E	Respiratory Disorder	☐ Yes	☐ No	M	Arthritis, Back, Bone, Joint Disord	☐ Yes	☐ No
F	Liver Disorder	☐ Yes	☐ No	N	Seizures, Convulsions, Epilepsy	☐ Yes	☐ No
G	High Blood Pressure	☐ Yes	☐ No	O	Any Other Medical Condition (not listed abov	☐ Yes	☐ No
H	AIDS / HIV / Immune System Disorder	☐ Yes	☐ No				

2. Within the past 5 years, have you or any dependent ever had an application for insurance declined, postpon rated 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 c prescription management, surgery, or hospitalization? ☐ Yes ☐ 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? ☐ Yes ☐ No

* **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 hospitalizatio 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 provide

7.

Question Number	Family Member	Disease / Diagnosis / Treatment	Date of Onset Month / Year	Date Last Seen By Physician	Remaining Symptoms or Problems

(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 contra which I am applying for coverage. I understand and agree that the insurance applied for shall not take effect until approved by the insura office. I have read, or have had read to me, the completed application and I realize that any false statements or misrepresentation in the in loss of coverage under the contract. I agree to disclose any updates to the answers and statements on this Employee Health Applicatio 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 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 Informat Healthcare Financial Group, LLC and Medova's respective carriers. I authorize Medova Healthcare and Medova's respective carriers to ass health care services, payment information, or account resolution. Medova Healthcare and Medova's respective carriers will not use this in purposes other than underwriting, eligibility, precertification and authorization, utilization management, case management, disease mana 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 fro 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 r recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 C.F.R. Part 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 respe 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 d 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 and duties of Medova Healthcare in conducting its administrative, care coordination, member services, and population health duties and hereby agree to abide by the terms and conditions of the summary plan documents which consist of the employee benefit booklet and sc contain the benefits, limitations, and exclusions applicable to my health and other benefit coverage. I hereby acknowledge that I may obt documents from my employer directly. I hereby consent to receive (i) from my employer, an electronic version of the Summary Plan Doc Benefits and Coverage, HIPAA Portability Notice, HIPAA Privacy Notice, and other DOL, HHS, or IRS required participant notices and summ Medova Healthcare, an electronic version of my claims information, including explanation of benefits (EOBs), all of which will be available web portal. I understand that I can request a paper copy of these documents, update my contact information, and/or withdraw this autho (all without charge) by contacting Medova (with respect to EOBs and other claims information) or my employer directly (with respect to a listed above). Upon request, a customer service representative can explain my benefit coverage options. I have read and understand the declarations.

Employee Signature: _____ **Date:** _____