QualChoice® HEALTH INSURANCE

Group Employee Application 2017

The employee must fill out this application and is solely responsible for its accuracy and completeness. To avoid delay, please answer **all** questions. Be sure to sign and date your application along with all attachments and return it to your Group Administrator.

Section I: Employee Status

Group/Plan Sponsor Name	Are you a full-time, active employee? ☐ YES ☐ NO If No, give reason below. Reason: _____	Date you became a full-time employee MM / DD / YYYY

Employment Status. *Please check one only.*

☐ Hourly: Hours Worked Weekly: _____	☐ Salaried: Required if Group Term Life plan based on salary Annual Salary $ _____	☐ Other: *Please check one.* ☐ Management ☐ Non-Management

Please check one:

☐ New Employee **or** ☐ Open Enrollment **or** ☐ Enrolling due to Qualifying Event. ***If enrolling due to Qualifying Event, check type below.***

Type of Qualifying Event

☐ Birth ☐ Marriage (attach copy of marriage certificate) ☐ Retiree ☐ COBRA (complete COBRA/AR State Continuation below)
☐ Loss of Other Coverage: Last Date of Coverage: _____ Carrier Name _____
☐ Other: _____

COBRA/AR State Continuation

Effective Date (MM/DD/YYYY)	Termination Date (MM/DD/YYYY)	Reason for COBRA/AR State Continuation

Section II. Waiver of Coverage. This section MUST be completed if you or your dependents are declining any or all coverage.

☐ Check here if you are declining **ANY**, but not all, of the benefits your employer offers.
- Fill out this application and the *Decline Coverage Form* (p.5)**.**
- If declining coverage for your spouse and/or dependents, you must let us know on the *Decline Coverage Form* (p.5)

☐ Check here if you are declining **ALL** benefits your employer offers and fill out the *Decline Coverage Form* (p.5).

Section III. Benefit Selection

Based on what your employer offers, check (✓) the box below for each type of coverage you, your spouse, and/or dependents are choosing. *Check all that apply*.	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
Medical Coverage	☐	☐	☐	☐
Dental Coverage Ask your employer if Dental is offered before selecting.	☐	☐	☐	☐
Vision Coverage Ask your employer if Vision is offered before selecting.	☐	☐	☐	☐
Group Term Life and AD&D Ask your employer if Group Term Life and AD&D is offered before selecting. **NOTE:** This coverage is only available to full-time, active employees who get a W-2 wage.	☐			
Dependent Life ☐ YES ☐ NO				

Section IV. Employee Information

Employee Legal Name *(Last, First, Middle Initial)*	Social Security No.	Date of Birth (MM/DD/YYYY)	Gender M ☐ F ☐

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed	Home Phone No.	Work Phone No.	Cell Phone No.	E-Mail Address

Physical Address (**NO** P.O. Boxes)	City	State	Zip Code

Mailing Address (If same as physical address mark 'SAME'. If P.O. Box **must** include physical address above)	City	State	Zip Code

Section V. Dependent Information. Fill out this section for **all** dependents to be covered. Attach another sheet of paper, if needed. Sign, date and attach to this application. **NOTE**: Social Security Numbers are required under Centers for Medicare & Medicaid (CMS) regulations.

■ Legal Name of Spouse *(Last, First, Middle Initial)*	Zip Code of Residence	Social Security No.	Date of Birth MM/DD/YYYY	Gender M ☐ F ☐

■ **Check (✓) One:** ☐ Natural Child ☐ Stepchild ☐ Adopted Child ☐ Permanent Legal Custody

Legal Name of Dependent *(Last, First, Middle Initial)*	Social Security No.	Date of Birth MM/DD/YYYY	Gender M ☐ F ☐

Address (**ONLY** if different from Employee's Address in Section IV)	City	State	Zip Code

■ **Check (✓) One:** ☐ Natural Child ☐ Stepchild ☐ Adopted Child ☐ Permanent Legal Custody

Legal Name of Dependent *(Last, First, Middle Initial)*	Social Security No.	Date of Birth MM/DD/YYYY	Gender M ☐ F ☐

Address (**ONLY** if different from Employee's Address in Section IV)	City	State	Zip Code

■ **Check (✓) One:** ☐ Natural Child ☐ Stepchild ☐ Adopted Child ☐ Permanent Legal Custody

Legal Name of Dependent *(Last, First, Middle Initial)*	Social Security No.	Date of Birth MM/DD/YYYY	Gender M ☐ F ☐

Address (**ONLY** if different from Employee's Address in Section IV)	City	State	Zip Code

■ **Check (✓) One:** ☐ Natural Child ☐ Stepchild ☐ Adopted Child ☐ Permanent Legal Custody

Legal Name of Dependent *(Last, First, Middle Initial)*	Social Security No.	Date of Birth MM/DD/YYYY	Gender M ☐ F ☐

Address (**ONLY** if different from Employee's Address in Section IV)	City	State	Zip Code

IMPORTANT NOTE: By signing Section VIII of this application, you are certifying that each "Child" listed above is **under the age of 26** and either your son, daughter, stepson, stepdaughter, an individual legally adopted by you, or an individual lawfully placed with you for legal adoption or an individual for whom you have permanent legal custody. A foster child is NOT eligible to be enrolled as your "Child".

Do you have any disabled dependents age 26 or older? ☐ **YES** ☐ **NO**

If **YES**, Legal Name(s):____

Please submit **Disabled Dependent Request for Extension of Coverage** (at *QualChoice.com*, select Members, then Forms)

Section VI. Other Health Insurance. Complete this section **ONLY** if you chose **Medical Coverage** in **Section III.**

Will you, your spouse or dependents be continuing any other health insurance coverage, including Medicare? ☐ **YES** ☐ **NO**
If **YES,** fill out **Part 1** and/or **Part 2** below *as it applies.* Use another sheet of paper if needed. Sign, date and attach to this application.

Part 1: Medicare

Please check (✓)reason for Medicare coverage: ☐ Over Age 65 ☐ Disabled ☐ Kidney Disease	Medicare Beneficiary Legal Name	Medicare Health Identification Contact (HIC) NO.

Type of Medicare Coverage — *Check* (✓) *all that apply*

☐ Medicare Part A Effective Date _______________ ☐ Medicare Part B Effective Date _______________ ☐ Medicare Part D Effective Date_______________

Part 2: Other than Medicare. If continuing health coverage is other than Medicare, fill out the information below. If covered by more than one insurance plan, use a separate sheet of paper. Sign, date, and attach to your application.

Name of Insurance Company			Phone No.
Legal Name of Policyholder *(Last, First, MI)*	Date of Birth (MM/DD/YYYY)	Policyholder ID No.	Policy Effective Date (MM/DD/YYYY)

List below all individuals who are covered by this policy.

Legal Name *(Last, First, MI)*	Relationship	Effective Date of Coverage (MM/DD/YYYY)

For individuals listed above, are you responsible for providing primary health insurance coverage? ☐ **YES** ☐ **NO**

If **NO**, please name responsible party(ies): _____

Section VII. Group Term Life and AD&D (Accidental Death & Dismemberment)

NOTE: Group Term Life and AD&D only available to full-time, active employees who get a W-2 wage.

I choose the person(s) listed below as beneficiary(ies) under the certificate and cancel the appointment of any existing beneficiary. The total must equal 100%. ***Note:*** *Employee is beneficiary for dependent life coverage.*

PRIMARY			**Relationship**	**Percentage**
Legal Last Name	Legal First Name	MI		_____%
Legal Last Name	Legal First Name	MI		_____%
Legal Last Name	Legal First Name	MI		_____%

100%

CONTINGENT			**Relationship**	**Percentage**
Legal Last Name	Legal First Name	MI		_____%
Legal Last Name	Legal First Name	MI		_____%
Legal Last Name	Legal First Name	MI		_____%

100%

Section VIII. Understandings, Representations And Agreements. *If application is being submitted due to a qualifying event or a new hire, the Group/Plan Sponsor Administrator must sign.*

In signing below:

1. I acknowledge that coverage is underwritten by the following:
   - Point of Service (POS) Plans and Health Maintenance Organization (HMO) Plans: QCA Health Plan, Inc.
   - Preferred Provider Organization (PPO) Plans, Dental Plans, Group Term Life and AD&D: QualChoice Life and Health Insurance Company, Inc.
   - Vision Plans: National Guardian Life Insurance Company; administered by Superior Vision Services, Inc.
2. I understand that the benefits for which I (we) will be eligible are those described in the underwriting company's polices with my employer and may from time to time be changed. I understand that coverage will not become effective before the approved effective date.
3. I represent that the statements and answers given in this application (or any attachment hereto) are true, complete and correctly recorded to the best of my knowledge and belief.
4. I authorize any physician, medical practitioner, hospital, clinic or other medically-related facility, insurance or reinsurance company having Protected Health Information (PHI) about any physical or mental condition or treatment on me or any member of my family (if applicable), to give QualChoice, its respective agents, affiliates, reinsurers, appropriate reporting agencies or legal representatives any and all such information to use for underwriting or claims purposes. I understand these records may have information created by other persons or entities (including health care providers) as well as information regarding the use of drugs or alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I understand the purpose of the disclosure and use of my information is to allow QualChoice, its agents, affiliates, reinsurers or legal representatives to make decisions regarding eligibility, enrollment, underwriting and premium risk rating as permitted by applicable law.
5. I acknowledge the following as required by HIPAA and requested by the underwriting companies:
   a. I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization will remain in effect until revoked.
6. I understand that any PHI received will become a part of my record with QualChoice and QualChoice will not use, disclose or retain the PHI except as required or authorized by law. I agree that a photocopy of this authorization shall be as valid as the original. I understand that a copy is available to me upon request.
7. I understand that I am completing a joint life, dental, vision, and health application and that each response must be complete and accurate. I (we) request the indicated group medical, dental, and vision coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from my earnings.
8. I (we) have not given the broker/agent or any other persons any health information not included on the application. I (we) understand that QualChoice is not bound by any statements I (we) have made to any broker/agent or to any other persons, if those statements are not written or printed on this application and any attachments.
9. I understand that any fraudulent statement, omission, or intentional material misrepresentation may result in coverage being terminated or rescinded (voided), including dependent coverage, issued in reliance thereon, and that QualChoice may recover any monies and damages incidental and consequential that result.
10. My signature authorizes QualChoice to release necessary information obtained by QualChoice about me and any family members listed on this application to my Group/Plan Administrator and/or my employer's broker/agent. This authorization permits release of information related to substance use or abuse, but does not provide for the disclosure of psychotherapy notes as defined in 45 CFR § 164.501. I understand that I may terminate this authorization by sending a written notice to QualChoice, ATTN: Customer Service, P.O. Box 25610, Little Rock, AR 72221.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employee Legal Name – PLEASE PRINT	Employee Signature X	Date Signed (MM/DD/YYYY)
Group/Plan Sponsor Administrator Legal Name – PLEASE PRINT	Group/Plan Sponsor Administrator Signature X	Date Signed (MM/DD/YYYY)

NOTE: If application is being submitted due to a qualifying event or new hire, the Group/Plan Administrator must sign.

Please keep a copy of this authorization for your records.

QualChoice® HEALTH INSURANCE

Decline Coverage Form

Group Employee Application 2017

*I understand that I am eligible to apply for health coverage through my employer. I am **declining** coverage as checked below.*

Group/Plan Sponsor Name	**Employee Legal Name** *(Last, First, MI)*	**Social Security No.**

Type of coverage declined *(check all that apply)*:	☐ **Medical** *Also complete **Medical Only** section below.*	☐ **Dental**	☐ **Vision**
Coverage is declined for *(check all that apply)*:	☐ Self ☐ Spouse ☐ Dependent(s)	☐ Self ☐ Spouse ☐ Dependent(s)	☐ Self ☐ Spouse ☐ Dependent(s)

MEDICAL ONLY. Please check (✓) one reason for declining medical coverage.

☐ Covered by spouse's group coverage
Name of Carrier: _____

☐ Enrolled in other insurance plan
Name of Carrier: _____

☐ Covered by Medicare/CHIP or State-sponsored coverage

☐ Covered by TRICARE or CHAMPUS

☐ Other (Explain): _____

PLEASE READ AND SIGN BELOW

By way of signature below, I certify the following:

- I have been given the opportunity to apply for the coverage made available through my employer under the applicable policy. The coverage and the policy have been thoroughly explained to me, and I decline to apply for coverage for myself and/or my dependent(s).
- I understand that if I decline to apply now and I apply for coverage at a later date, my request may be deferred until the annual Open Enrollment period.

Special Enrollment Period. If you are declining enrollment for yourself (including your dependents) because of other insurance coverage, in order to enroll yourself and/or your dependents in your employer's plan in the future you must:

- Indicate on this form that the reason you and/or your dependent(s) are declining coverage now is because you and/or your dependent(s) have coverage under another group health plan; and,
- Submit a *Group Employee Application* to enroll yourself and/or your dependent(s) within 30 days after coverage ends under the other group health plan. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, and/or your new dependent(s), provided that you request enrollment within **30 days** after the marriage, **90 days** after birth, **60 days** after adoption, or **60 day**s after filing of petition for adoption.

Also, if you and/or your dependent(s) lose Medicaid coverage or coverage under the state children's health insurance program (such as, CHIP, ARKids First) because you and/or your dependent(s) are no longer eligible, or you and/or your dependent(s) qualifies for state assistance in paying your employer group medical premiums, you may be able to enroll yourself, and/or your dependent(s) provided you notify us within **60 days** following the date of the event.

Any applicant who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employee Signature - **REQUIRED** Date Signed (MM/DD/YYYY)

X