

# NEBRASKA UNIFORM GROUP HEALTH APPLICATION

## EMPLOYER DATA

Employer \_\_\_\_\_ Group Number \_\_\_\_\_ Phone \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Fax \_\_\_\_\_

## EMPLOYEE DATA

Employee Name \_\_\_\_\_ Social Security Disabled? Y N Medicare Enrolled? Y N Sex: M F  
 Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Work Phone # \_\_\_\_\_ Home Phone # \_\_\_\_\_ Email \_\_\_\_\_  
 DOB \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Social Security \_\_\_\_\_ Job Title \_\_\_\_\_ Date of Hire \_\_\_\_\_  
 Primary Care Physician \_\_\_\_\_  
 Average Hours Worked per Week \_\_\_\_\_ Salary/Wage \$ \_\_\_\_\_ Employment Status:  Full-Time  Part-Time  Retired  COBRA  
 Marital Status:  Married  Single  Divorced  Legally Separated  Widowed

## WAIVER OF COVERAGE

<b>I decline coverage for:</b> <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Vision <input type="checkbox"/> Disability	<b>Declining coverage due to existence of other coverage:</b> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Spouse's Employer's Plan</td> <td><input type="checkbox"/> Individual Plan</td> </tr> <tr> <td><input type="checkbox"/> Covered by Medicare</td> <td><input type="checkbox"/> VA Eligibility</td> </tr> <tr> <td><input type="checkbox"/> COBRA from prior employer</td> <td><input type="checkbox"/> Tri-Care</td> </tr> <tr> <td><input type="checkbox"/> I (we) have no other coverage at this time</td> <td><input type="checkbox"/> Medicaid</td> </tr> <tr> <td><input type="checkbox"/> Disability</td> <td><input type="checkbox"/> Other, explain:</td> </tr> </table>	<input type="checkbox"/> Spouse's Employer's Plan	<input type="checkbox"/> Individual Plan	<input type="checkbox"/> Covered by Medicare	<input type="checkbox"/> VA Eligibility	<input type="checkbox"/> COBRA from prior employer	<input type="checkbox"/> Tri-Care	<input type="checkbox"/> I (we) have no other coverage at this time	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Disability	<input type="checkbox"/> Other, explain:
<input type="checkbox"/> Spouse's Employer's Plan	<input type="checkbox"/> Individual Plan										
<input type="checkbox"/> Covered by Medicare	<input type="checkbox"/> VA Eligibility										
<input type="checkbox"/> COBRA from prior employer	<input type="checkbox"/> Tri-Care										
<input type="checkbox"/> I (we) have no other coverage at this time	<input type="checkbox"/> Medicaid										
<input type="checkbox"/> Disability	<input type="checkbox"/> Other, explain:										
I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a late enrollee, if applicable. I also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.											
Signature _____ Date Signed _____											

## COVERAGE SELECTED

**Please indicate your coverage choice – Note: All coverages may not be available from all carriers**

Medical	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Employee/Child(ren)	<input type="checkbox"/> Employee/Spouse/Child(ren)
	<b>Plan selection</b>		<input type="checkbox"/> PPO	<input type="checkbox"/> HDHP
	<input type="checkbox"/> Other, define:			
Dental	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Employee/Child(ren)	<input type="checkbox"/> Employee/Spouse/Child(ren)
Life	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Employee/Child(ren)	<input type="checkbox"/> Employee/Spouse/Child(ren)
Vision	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Employee/Child(ren)	<input type="checkbox"/> Employee/Spouse/Child(ren)
Disability	<input type="checkbox"/> Employee/Short Term		<input type="checkbox"/> Employee/Long Term	

## DEPENDENT DATA

Name (First, MI, Last)	Sex	Height	Weight	Birth date	Social Security Number	Primary Care Physician	Full-Time Student	Medicare Enrolled?	Social Security Enrolled
Spouse	<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent	<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent	<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent	<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent	<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent	<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

UNI\_APP1 Agent No: \_\_\_\_\_ Employee Name \_\_\_\_\_





**AUTHORIZATION AND CERTIFICATION**

I understand and agree with the following statements with regard to my application for coverage through an insurance carrier:

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions, but those over the maximum age will be verified when a claim is filed. I have read and understand the Pre-Existing Condition Exclusion and the Special Enrollment Rights and know if I refuse medical coverage, I and my dependents must wait for the next open enrollment unless I become eligible during a Special Enrollment. If I refuse dental coverage, I and my dependents may enroll later, but this will affect the level of benefits. If I refuse life or disability coverage, I may apply later, but I must show proof of good health, and coverage will be subject to approval by the Carrier. If I refuse coverage, I cannot enroll after retirement.
- I understand that the coverage applied for will not start until after this application and the appropriate coverage rates are received and accepted by the Carrier and an effective date of coverage is established by the Carrier, I further agree that the Carrier is not liable for a claim before the effective date of coverage and all policy provisions apply. During the first two years coverage for life or disability or medical is in force, false statements, omissions or material misrepresentations can cause changes in that coverage, including cancellation back to the effective date.
- Any person who, with intent to defraud or knowingly is facilitating a fraud against an insurer, submits an application or files a claim with false or deceptive statements, may be guilty of insurance fraud.
- For life and disability coverages, I authorize any health care provider who has personal information - including physical, mental, drug or alcohol use history - regarding me or a dependent, to give such data to the Life or Disability Carrier agents and employees of the Life or Disability Carrier and I authorize the Life or Disability Carrier to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by the Life or Disability Carrier for determining eligibility for life and disability coverage. Information will not be used for any purposes prohibited by law.
- I also understand collection of social security numbers for myself and my dependents will be used by the Carrier only as allowed by law.
- For life coverage, I understand that as the employee, the insurance I and my dependents have applied for will begin on the effective date of coverage, provided I am at work on that date. If I am not actively at work on such date - subject to the terms of the group policy - coverage may not go into effect until after my return to work. Furthermore, I understand that no insurance may become effective for any member of my family while he/she is in a period of limited activity.
- For medical coverage, I authorize pharmacy benefit managers, "health care providers," including, but not limited to, surgeons, physicians, psychologists, nurses, social workers, health care facilities and other entities covered under the HIPAA Privacy Rule and their agents and employees, to release and disclose my personal health information, including, but not limited to, all health and mental records, including those records protected by Federal or State law relating to the diagnosis or treatment of AIDS or AIDS-related Complex, Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental health and substance abuse, the use of alcohol, drugs and tobacco, and the past, present or future treatments or conditions for myself or for my dependents eligible for health care coverage to the Carrier, its agents and employees, for purposes of underwriting my application for coverage, and making eligibility, premium rating and enrollment decisions relating to any coverage I have, have applied for or may in the future apply for with the Carrier or other entities covered under the HIPAA Privacy Rule. I further understand that the personal health information described above may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws. This authorization shall remain in force two years following the date of my signature. I may revoke this authorization in writing at any time by sending the request for revocation to the Carrier. I understand that a revocation is not effective until received by the Carrier and that any revocation is not effective to the extent the Carrier or Providers have relied on the protected health information disclosed to them. This Authorization and Certification does not authorize the redisclosure of medical information except as otherwise stated herein, Federal and State regulations do not allow further disclosure of mental health, substance abuse and AIDS/HIV related information. The Carrier maintains the confidentiality of all information received and it will not be released to any person or facility unless you apply for life and/or disability coverage underwritten by the Life or Disability Carrier in which case the application, without any further health records or Attending Physician Statements (APS) received, will be released to the Life or Disability Carrier. I understand that if I refuse this authorization, the Carrier may not make an eligibility determination, and I will not be considered for coverage with the Carrier.

I hereby authorize the following Carriers, their reinsurers and their legal representatives to receive, use and disclose my, my spouse and my dependent child(ren)'s Protected Health information for the purposes of insurance coverage. I authorize the Carriers to disclose my, my spouse and my dependent child(ren)'s Protected Health information between themselves, to reinsuring companies, to the plan administrator or plan sponsor (if other than the employer), insurance intermediaries or other persons or organizations performing business or legal services in connection with the purpose of insurance coverage. *(Either you or your broker must list all Carriers that are to receive this application for insurance).*

Carrier Blue Cross and Blue Shield of Nebraska      Carrier \_\_\_\_\_      Carrier \_\_\_\_\_

Carrier \_\_\_\_\_      Carrier \_\_\_\_\_      Carrier \_\_\_\_\_

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I further certify that, after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that the Carrier will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, the Carrier will be entitled to declare any contract or coverage issued pursuant to this application void and to refuse allowance on benefits to any person thereunder, which means that any claims incurred will become my liability. If the group policy does not require my contribution, I understand that I cannot decline any coverage unless the policy indicates otherwise. If the group policy requires my contribution, I authorize my employer to deduct from my pay. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from the Carrier.

**Print Name** \_\_\_\_\_

**UNI\_APP1**      **Signature** \_\_\_\_\_      **Date Signed** \_\_\_\_\_



## **YOUR RIGHTS AND RESPONSIBILITIES**

### **SPECIAL ENROLLMENT RIGHTS**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents other coverage). However, you must request enrollment within 30 days after your or your dependent's other coverage ends (or after the employer stops contributing toward the other coverage).

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 your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

If you are declining coverage for yourself or your dependents because of coverage under Medicaid or a State Child Health Insurance Program (SCHIP), you may be able to enroll yourself or your dependents in this plan if that coverage terminates due to a loss of eligibility. You must request enrollment in the plan no later than 60 days after the termination of coverage.

Additionally, if you decline coverage and you or your dependents become eligible for premium assistance for this group health plan under Medicaid or SCHIP, you or your dependents may be able to enroll in the plan at that time. You must request enrollment no later than 60 days after the date you are determined to be eligible for the premium assistance.

To request special enrollment or obtain more information, contact the Blue Cross and Blue Shield of Nebraska Membership Service Center.

### **WAITING PERIOD FOR PRE-EXISTING CONDITIONS NOTICE**

This Plan imposes a waiting period for pre-existing conditions. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in an eligibility waiting period for coverage, the six-month waiting period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is

enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the waiting period for pre-existing conditions and creditable coverage should be directed to our Member Service Center at (402) 390-1820 or toll-free 1-800-642-8980.