UTAH SMALL EMPLOYER
EMPLOYEE HEALTH INSURANCE APPLICATION

OFFICE USE ONLY
Policy / Group No.
Effective Date
New Hire Waiting Period

REASON FOR ENROLLMENT (mark all that apply)		
❒ New Group	❒ Newborn	❒ Loss of Coverage_____
❒ Open Enrollment	❒ Court Order	❒ Marriage_____
❒ New Hire	❒ Dependent Addition	❒ Divorce_____
❒ New Application	❒ Other:_____	❒ Military Leave of Absence(USERRA)_____
❒ COBRA	❒ Utah mini-COBRA	
Length of continuation coverage: ❒12 mos. ❒18 mos. ❒36 mos. ❒Other:		
Original Qualifying Event Date:	Qualifying Event Date:	Date of Event:
❒ WAIVER OF COVERAGE Individuals waiving coverage complete Waiver of Coverage.		

A. EMPLOYER INFORMATION

Employer _____ Is this a division? ❒ Yes ❒ No If "Yes," name of parent company_____

B. EMPLOYEE INFORMATION

Name (Last) _____ (First)_____ (MI) _____ Job Title _____ Hrs/Week _____

Employment status ❒ Full-time ❒Owner/business partner ❒Retired ❒Other_____ Hire Date___/___/_____ Rehire Date___/___/_____

Marital Status ❒ Legally Married ❒ Single ❒ Divorced ❒ Widowed ❒ Domestic Partner*

Home Address _____ Apt. _____ City _____ State _____ Zip _____

Mailing Address _____ Apt. _____ City _____ State _____ Zip _____

Home/Cell Phone (____) _____ Business Phone (____) _____ Email Address: _____

If you are American Indian or Alaska Native, provide the state and name of your federally-recognized tribe: _____

C. ENROLLING EMPLOYEE / SPOUSE / DOMESTIC PARTNER* / DEPENDENTS

List yourself and all dependents applying for coverage. Attach a separate sheet if necessary.

	Name (Last, First, Middle)	Social Security # (for insurer use only)	Date of Birth MM/DD/YYYY	Gender	Tobacco Use:
Employee				❒ Male ❒ Female	❒ Yes ❒ No
Spouse/ Domestic Partner*				❒ Male ❒ Female	❒ Yes ❒ No
Dependent				❒ Male ❒ Female	❒ Yes ❒ No
Dependent				❒ Male ❒ Female	❒ Yes ❒ No
Dependent				❒ Male ❒ Female	❒ Yes ❒ No

*Check with your employer to determine if domestic partner coverage is available.

D. CURRENT COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health care coverage, Medicaid, or Medicare currently in effect. This will be used to determine if benefits will be coordinated. Each person applying for coverage must be listed below. If no health care coverage is in effect, indicate NONE. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependents' health care coverage so that the insurer can determine whose coverage is primary. Attach a separate sheet if necessary.

Name of Individual	Insurer (List policyholder name, insurer name and phone number)	Date of Coverage MM/YY Start Date	End Date	Will coverage continue?	Type of Coverage (Check all that apply)
Employee:				❒ Yes ❒ No	❒ Employer group ❒ Individual ❒ Medicare ❒ Governmental ❒ Other_____
Spouse/Domestic Partner:				❒ Yes ❒ No	❒ Employer group ❒ Individual ❒ Medicare ❒ Governmental ❒ Other_____
Dependent:				❒ Yes ❒ No	❒ Employer group ❒ Individual ❒ Medicare ❒ Governmental ❒ Other_____
Dependent:				❒ Yes ❒ No	❒ Employer group ❒ Individual ❒ Medicare ❒ Governmental ❒ Other_____
Dependent:				❒ Yes ❒ No	❒ Employer group ❒ Individual ❒ Medicare ❒ Governmental ❒ Other_____

E. ACKNOWLEDGMENT AND SIGNATURE

I agree to abide by the insurer's enrollment provisions. I understand that coverage cannot start until after the waiting period. I authorize my employer to act as my agent in all matters of administration of the group program.

I acknowledge that I have had the opportunity to waive coverage for myself and any eligible dependents.

If the policy contains a voluntary arbitration provision: ANY MATTER IN DISPUTE BETWEEN YOU AND THE INSURER MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION OR OTHER RECOGNIZED ARBITRATOR, A COPY OF WHICH IS AVAILABLE ON REQUEST FROM THE INSURER. THE INSURER SHALL BEAR THE COSTS OF ARBITRATION, FILING FEES, ADMINISTRATIVE FEES AND ARBITRATOR FEES. OTHER EXPENSES OF ARBITRATION, INCLUDING, BUT NOT LIMITED TO: ATTORNEY FEES, EXPENSES OF DISCOVERY, WITNESSES, STENOGRAPHER, TRANSLATORS, AND SIMILAR EXPENSES, WILL BE BORNE BY THE PARTY INCURRING THOSE EXPENSES. ANY DECISION REACHED BY ARBITRATION SHALL BE BINDING UPON BOTH YOU AND THE COMPANY. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY'S FEES, IF ALLOWED BY STATE LAW, AND MAY BE ENTERED AS A JUDGMENT IN ANY COURT OF PROPER JURISDICTION.

I certify that all information completed on this form is true, correct and complete. I acknowledge that if any information provided is false, the insurer may without advance notice pursue any remedies available under state or federal law, including declaring the coverage null and void and canceling the coverage retroactive to its original effective date.

I have read the Acknowledgment of this document and agree to its terms.

Employer: _____

Employee Name: (Last) _____ (First)_____ (MI) _____

Employee Signature_____Date_____

WAIVER OF COVERAGE

COMPLETE WHEN WAIVING COVERAGE FOR SELF AND/OR DEPENDENTS

Employee Name: (Last) _____ (First)_____ (MI) _____

Employer: _____

INDIVIDUALS WAIVING COVERAGE

Name of individual waiving coverage	Reason for waiving coverage	Insurer (Including policyholder name, insurer name and phone number)	Will coverage continue?
Employee:	❒ Other employer group coverage ❒ Individual coverage ❒ Governmental (Medicare, Medicaid, Tricare, etc.) ❒ Other_____		❒ Yes ❒ No
Spouse / Domestic Partner:			
Dependent:			
Dependent:			
Dependent:			

ACKNOWLEDGEMENT AND SIGNATURE

I acknowledge that I have had the opportunity to enroll, but do not wish to make application for those individual(s) listed above. In waiving coverage, I am aware that waiving individuals (including myself, if I am waiving) may not enroll until my group's anniversary, unless the waiving individual qualifies for a Special Enrollment Period (SEP). If I have waived enrollment for myself or any of my dependents (including my spouse/domestic partner) because of other health care coverage or group health plan coverage, I may in the future be qualified for a SEP and be able to enroll the waived individuals in this plan, provided I request enrollment within 30 days after the other coverage of the individual(s) ends due to loss of eligibility or an employer's ceasing to contribute toward that other coverage (within 60 days if the other coverage was Medicaid or CHIP). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I further certify that all information completed on this Waiver of Coverage form is true, correct and complete.

Employee Signature_____Date_____