2020 Employee Health Application Enrollment Form

Please complete the below form in its entirety in order to ensure the most efficient enrollment with Lifestyle Health Plans.
Any missing information may delay implementation and processing.

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

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

- **MEDICAL**

☐ I elect coverage
☐ I decline coverage

Coverage Level (Choose)
☐ Employee Only
☐ Employee / Spouse
☐ Employee / Child(ren)
☐ Family

Plan Design Selected
☐
☐
☐
☐

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:

- **DENTAL**

☐ I elect coverage ☐ I decline coverage	**Coverage Level (Choose)** ☐ Employee Only ☐ Employee / Spouse ☐ Employee / Child(ren) ☐ Family	**Plan Design Selected** ☐ ☐

- **VISION**

☐ I elect coverage ☐ I decline coverage	**Coverage Level (Choose)** ☐ Employee Only ☐ Employee / Spouse ☐ Employee / Child(ren) ☐ Family	**Plan Design Selected** ☐ ☐

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

Self: Height ____ feet _____ inches; Weight _____ lbs. **Spouse: Height ____ feet _____ inches; Weight _____ lbs.**

Please answer the following health questions regarding any medical conditions or medical treatment for you and your family.

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

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 Disorder	☐ 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 above)	☐ 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, postponed, 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 care, 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 in 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 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**

7. **Are you or any of your dependent(s) disabled?** ☐ Yes ☐ No

* **If Yes, please provide information below for each disabled family member on the next page (Box9)**

8. **In the past 12 months, have you or any of your dependent(s) been taking any medications, prescriptions or injections?** ☐ Yes ☐ No

* **If Yes, please provide detail in the Prescriptions / Medications section on the next page (Box 10)**

If you answer "Yes" to any of the questions above, please provide detail in space provided on the next page.

9.	Question Number	Family Member	Disease / Disability /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.)

10.	**Prescriptions / Medications –** List any medications, prescriptions, or injections taken in the last 12 months			
	Family Member Name	**Medication / Rx / Injection**	**Dosage**	**Medical Condition**	**Currently Taking?**
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

(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 of insurance under which I am applying for coverage. I understand and agree that the insurance applied for shall not take effect until approved by the insurance carrier at its home 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 may result in loss of coverage under the contract. I agree to disclose any updates to the answers and statements on this Employee Health Application that may arise prior to 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 ("PHI") to Medova Healthcare Financial Group, LLC and Medova's respective carriers. I authorize Medova Healthcare and Medova's respective carriers to assist me in obtaining health care services, payment information, or account resolution. Medova Healthcare and Medova's respective carriers will not use this information for any purposes other than underwriting, eligibility, precertification and authorization, utilization management, case management, disease management, and 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 below. 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 re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 C.F.R. Part 164), and 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 at 345 N. Riverview, Suite 600, Wichita, KS 67203. Revocation of this authorization will not affect any action that Medova Healthcare, Medova's respective carriers, or any 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 normal functions and duties of Medova Healthcare in conducting its administrative, care coordination, member services, and population health duties and responsibilities. I also hereby agree to abide by the terms and conditions of the summary plan documents which consist of the employee benefit booklet and schedule of benefits and contain the benefits, limitations, and exclusions applicable to my health and other benefit coverage. I hereby acknowledge that I may obtain a copy of these documents from my employer directly. I hereby consent to receive (i) from my employer, an electronic version of the Summary Plan Documents, Summary of 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 on the online web portal. I understand that I can request a paper copy of these documents, update my contact information, and/or withdraw this authorization at any time (all without charge) by contacting Medova (with respect to EOBs and other claims information) or my employer directly (with respect to all other disclosures listed above). Upon request, a customer service representative can explain my benefit coverage options. I have read and understand the above conditions and declarations.

Employee Signature: _____ **Date:** _____