



LARGE GROUP (51+) ENROLLMENT FORM

Group No. _____

OFFICE USE ONLY

Effective Date _____

PEC _____

New Hire Waiting Period _____

REASON FOR ENROLLMENT

New Group Newborn*

Open Enrollment Marriage*

New Hire* Divorce*

Loss of Coverage* Court Order*

COBRA/State Continuation*

Reason _____

Other* _____

***Date of Event:** _____

HMO

Mountain

Peak

Peak Traditional

Peak QHDHP

Dental

Other _____

Plus (POS)

Peak Plus

Peak Plus Traditional

Peak Plus Extended

Peak Advantage

Peak Plus QHDHP

Fill out each section below COMPLETELY and LEGIBLY. Failure to do so will delay your enrollment.

A. EMPLOYER INFORMATION

Employer _____

Hire Date _____ Rehire Date _____

Location _____ Is this a division? Yes* No

*If "Yes," name of parent company _____

| Coverage | Self | Spouse | Child(ren) | COBRA | State Cont. Coverage |
|----------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Medical | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dental | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

B. EMPLOYEE INFORMATION

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

Marital Status Married Single Divorced Widowed / Email Address: _____

Address _____ Apt. _____ City _____ State _____ ZIP _____

Home (or OTHER) Phone (_____) _____ Business Phone (_____) _____

Spouse's Employer _____ Spouse's Business (or OTHER) Phone (_____) _____

If covering dependent(s) due to court order, attach a copy of court documentation. Please note address and telephone number *if different than subscriber's*:
Address _____ Phone (_____) _____

C. OTHER HEALTH COVERAGE (In addition to Altius)

After enrollment, will you or your dependent(s) have other **health** insurance *in addition to Altius*? Yes (complete this section) No (go to section D)

What Coverage? Medical _____ Name of Carrier _____ Rx Medicare/Medicaid** Other Carrier's Phone (_____) _____

Policy Holder's Name _____ Policy # _____ Effective Date of Coverage _____

**If other coverage is Medicare or Medicaid, are you or any of your dependents disabled?
 No Yes - Indicate Name(s) _____

If this 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 dependent(s)' health care insurance so that Altius can determine whose coverage is Primary.

D. PRIOR HEALTH COVERAGE (before Altius)

Did you or your dependent(s) have other **health** insurance *prior to Altius*? Yes (complete this section) No (go to section E)

What Coverage? Medical _____ Name of Carrier _____ Rx Medicare/Medicaid Prior Carrier's Phone (_____) _____

Effective Date _____ Term Date _____ Policy Holder's Name _____ Policy# _____

Note: If you have had health care coverage within the last 63 days, your Pre-Existing Condition (PEC) waiting period limitation may be partially or completely waived. To determine if this applies to you, you must provide proof of prior coverage, such as a Certificate of Creditable Coverage from your previous carrier. Submission of prior coverage information does not automatically waive any Pre-Existing Condition Limitation. However, you will be subject to an automatic Pre-Existing Condition Waiting Period of up to 12 months until we receive evidence of prior coverage.

E. ENROLLING SUBSCRIBER/SPOUSE/DEPENDENTS (attach separate sheet if necessary)

| | Social Security # | NAME - Last | First | MI | Date of Birth | Age | M/F | Other Coverage | | |
|-----------|-------------------|-------------|-------|----|---------------|-----|-----|----------------|-------|-------------|
| | | | | | | | | Medical | Rx | Medicare |
| employee | | | | | | | | Y / N | Y / N | A / A&B / D |
| spouse | | | | | | | | Y / N | Y / N | A / A&B / D |
| dependent | | | | | | | | Y / N | Y / N | A / A&B / D |
| dependent | | | | | | | | Y / N | Y / N | A / A&B / D |
| dependent | | | | | | | | Y / N | Y / N | A / A&B / D |
| dependent | | | | | | | | Y / N | Y / N | A / A&B / D |
| dependent | | | | | | | | Y / N | Y / N | A / A&B / D |

F. AGREEMENT and AUTHORIZATION

I have read and fully understand the Agreement and Authorization on the reverse side of this document and agree to its terms.

Subscriber Signature _____ Date _____

If you have any questions regarding this form, please call Customer Service at (800) 377-4161.

OFFICE USE ONLY

G. AGREEMENT and AUTHORIZATION

I hereby apply for membership with Altius Health Plans (Altius) for the persons listed on this enrollment form (collectively referred to as Enrolled Family). I understand that my enrollment and benefits are in accordance with and described in the applicable Evidence of Coverage and Group Service Agreement. I authorize 1) all health providers and insurers to furnish Altius, and 2) all health providers and Altius to furnish all insurers and health providers records concerning me or any member of my Enrolled Family for whom information is requested for any purpose required for the coverage of benefits including, but not limited to, the coordination of payments with other insurers or in connection with the provision of medical care. I understand that I or my authorized representative may receive a copy of this form containing this authorization for disclosure of information. A photographic copy of this authorization shall be valid as the original. I authorize my employer to deduct from my wages the amount required (if any) to cover my contribution for coverage. I certify that all the above information is correct. For claim adjudication purposes, this authorization is valid for the duration of my coverage for health benefits through Altius. For purposes of collecting information for an insurance policy application, policy reinstatement, or a request for change in policy benefits, this authorization shall remain valid for 30 months from the date the authorization is signed.

I understand that if I and/or my dependent(s), if any, waive coverage, I may not again be eligible for coverage until the next open enrollment period, which is established by my employer and Altius. If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my dependents in this plan if I or my dependents lose eligibility for that other coverage (or if the employer stops contributing towards my or my dependents' other coverage). However, I must request enrollment within 30 days after my or my dependents' other coverage ends (or after the employer stops contributing toward the other coverage). 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. However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Requests for special enrollment or more information may be directed to Altius Health Plans, Customer Service Department, 801-323-6200 or 800-377-4161.

By signing this form, I agree on behalf of myself and my Enrolled Family that Altius may use or disclose to third parties the information contained on this enrollment form and individually identifiable health information relating to my Enrolled Family for purposes of administering my health insurance benefits including treatment, payment, or health care operations, as those terms are explained in detail in the Altius Notice of Privacy Practices and to the extent permitted by law. My Enrolled Family's consent includes agreement for the use or disclosure of health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness, including substance abuse, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV). By signing this form, I also agree on behalf of myself and my Enrolled Family, to the extent permitted by law, health care providers, insurers, claims administrators, employers, and others may disclose my Enrolled Family's personal information including individually identifiable health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness including substance abuse, AIDS, ARC, or HIV to Altius for administration of health insurance benefits including treatment, payment, or health care operations purposes and other purposes permitted by law.

I have read and agree to the statements above.

Please sign and date the front side of this form