

# SMALL GROUP (2-50) 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:** \_\_\_\_\_

<p><b>Plus (POS)</b></p> <p><input type="checkbox"/> Peak Plus</p> <p><input type="checkbox"/> Peak Plus Extended</p> <p><input type="checkbox"/> Peak Advantage</p> <p><input type="checkbox"/> Peak Plus QHDHP</p> <p><input type="checkbox"/> Other _____</p>	<p><b>Health Suite</b></p> <p><input type="checkbox"/> Peak Plus 90%</p> <p><input type="checkbox"/> Peak Plus 80%</p> <p><input type="checkbox"/> Peak Plus 70%</p> <p><input type="checkbox"/> Peak Plus Traditional</p>
<p><input type="checkbox"/> Dental</p> <p><input type="checkbox"/> Other _____</p>	

**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 - part 1

I attest that all information on this form is accurate. I have read the Agreement and Authorization on page 3 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. HEALTH HISTORY

Instructions: Answer each question for each individual applying for coverage. Circle the specific item and check the appropriate box for each question. For each "Yes" answer, give complete and specific details in section H and/or I.

**Please complete the following questions:**

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Have you, your spouse or any eligible child (whether or not proposed for insurance) missed her last menstrual period?<br>Date of last menstrual cycle: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you or your spouse financially responsible for an unborn child, or do you anticipate adopting a child in the next 12 months?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. To the best of your knowledge, has any applicant been denied health or life insurance or been issued a modified or rated policy?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have a spouse or dependent(s) who are <i>not</i> applying for coverage? If yes, complete (a) and (b) below. (Refer to Section J )                     | <input type="checkbox"/> | <input type="checkbox"/> |
| a. List the reason(s) why your spouse and/or dependents are not applying for coverage on this plan:<br>_____<br>_____   |                          |                          |
| b. Current health status of those not applying for coverage:<br>_____<br>_____  |                          |                          |

**Within the past 12 MONTHS has any applicant:**

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 5. Consulted or received treatment from a doctor, chiropractor, counselor, therapist, or other health care provider, including routine and wellness care? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Had a health condition, problem, or disorder for which medical advice or treatment has <i>not</i> been sought?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Been prescribed or taken any prescription or over-the-counter medications, drugs, or shots (including immunizations, birth control, etc.)?             | <input type="checkbox"/> | <input type="checkbox"/> |

**Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following:**

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 8. Physical, neurological, or neuromuscular impairments?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Recurring headaches, migraines, head injury, epilepsy, seizures, or convulsions?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Mental health counseling, psychotherapy, depression, stress, anxiety, mental health disorder, or chemical imbalance that required consultation or medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Acne, psoriasis, eczema, growths (except warts), abnormal moles, abnormal birthmarks, or any other skin disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Eyes, ears, nose, sinus, or throat disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Jaw disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Allergies, hay fever, or adverse drug reactions and/or side effects?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. RSV, reactive airway disease, lung disease, or any other respiratory system disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Thyroid disorder, goiter, or any other lymph system disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Breast lumps, breast augmentation, or breast reduction?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Chest pain, high blood pressure, high cholesterol, irregular heart beat, or any other heart condition?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Back, neck, spinal, or joint disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Connective tissue disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Hemophilia, anemia, blood or bleeding disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Obesity, bulimia, anorexia, or any other eating disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Kidney stones, jaundice, nephritis, or any other disorder of the liver, kidneys, or pancreas?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Hemorrhoids, polyps, or any other rectal disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Ulcers, hernias, chronic diarrhea, diverticulitis, diverticulosis, irritable bowel syndrome, reflux, GERD, or any other gallbladder or digestive disorder?    | <input type="checkbox"/> | <input type="checkbox"/> |

**Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following:**

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 26. Impotence, prostate or testicular disorder, or abnormal PSA?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Bladder or urinary disorder, or incontinence?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Sexually transmitted diseases?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Irregular bleeding, abnormal Pap smear/test, endometriosis, recurring pelvic pain, or pelvic inflammatory disease?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Infertility, fertility evaluation or treatment (including medication), miscarriage, complications related to pregnancy (including premature births), or any other disorder of the reproductive system? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Varicose veins, or any other circulatory disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Foot, knee, or bone disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Fracture or dislocation?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Tobacco use (chewing or smoking)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Condition for which hospitalization, tests, consultation, evaluation, surgery, or medication <i>have been advised, but not completed</i> ?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Inability to work or to perform routine daily functions for more than 2 weeks (other than pregnancy)?  | <input type="checkbox"/> | <input type="checkbox"/> |

**Within the past 10 YEARS has any applicant been diagnosed with or treated for any of the following:**

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 37. Alcohol use/abuse, been advised to reduce/limit alcohol use, or attended Alcoholics Anonymous (or similar program) for his/her own alcohol consumption?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc, spinal bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, or spondylosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Colitis, colostomy, or ileostomy?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Crohn's disease, lupus, gout, arthritis, fibromyalgia, or scleroderma?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Cysts?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Drug dependency, abuse, or misuse of prescribed or non-prescribed drugs such as opiates, stimulants, depressants, and/or hallucinogens?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Hospitalization or surgery?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Stomach stapling, gastric bypass, or any surgical services for obesity?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Tuberculosis, asthma, sleep apnea, pleurisy, COPD, sarcoidosis, or emphysema?  | <input type="checkbox"/> | <input type="checkbox"/> |

**Has any applicant EVER been diagnosed with or treated for any of the following:**

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 46. Bipolar affective disorder, manic depression, schizophrenia, chronic organic brain syndrome, or psychotic disorder?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 47. Birth defect, premature birth, development or learning disability, mental impairment, Down syndrome, or autism?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. Cancer (including skin cancer) or tumors?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 49. Cirrhosis or hepatitis?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 50. Diabetes (type I or II)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 51. Heart murmur, heart attack, bypass surgery, blood clot, stroke, heart surgery, or coronary artery disease?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 52. Immune system diseases, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC)?     | <input type="checkbox"/> | <input type="checkbox"/> |
| 53. Joint replacement?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 54. Multiple sclerosis, muscular dystrophy, cerebral palsy, Lou Gehrig's disease (ALS), Parkinson's disease, Alzheimer's disease, or dementia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 55. Are you or any dependent(s) disabled? If yes, indicate name(s):<br>_____<br>_____  | <input type="checkbox"/> | <input type="checkbox"/> |

56. List below the height, current weight, and last year's weight for the employee and spouse.

**EMPLOYEE**

Height \_\_\_\_\_ ft. \_\_\_\_\_ in.  
Current Weight \_\_\_\_\_ lbs.  
Last Year's Weight \_\_\_\_\_ lbs.

**SPOUSE**

Height \_\_\_\_\_ ft. \_\_\_\_\_ in.  
Current Weight \_\_\_\_\_ lbs.  
Last Year's Weight \_\_\_\_\_ lbs.



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