



Commercial Group Health Insurance Application/Change Form

FOR INTERNAL USE ONLY

HIOS ID# _____

EC _____

CONFIDENTIAL

Please print clearly and complete all sections that apply. Signatures are required. Additional instructions included on Page 4.

Section 1: Employer Group & Benefit Information To be completed with your Group Administrator

County Of Wyoming

Employer Name

Association/Chamber Name (if applicable)

Check Desired Action
 Add Cancel Change

Group Administrator's Signature (required)

Date

Employee Number

Department Number

Medical Information

00130631

Medical Group Number (8 digits)

Who's covered?

- Self Only
- Self & Child(ren)
- Self & Spouse/Domestic Partner
- Family

Subgroup _____ Class _____

Medical Effective Date

Subscriber Status:

- Actively Working
- Retired
- Disabled
- Canceled
- COBRA

Dental Information

00055393

Dental Group Number

Who's covered?

- Self Only
- Self & Child(ren)
- Self & Spouse/Domestic Partner
- Family

Medical Plan Selection

- Univ PPO Sig Ded 3 (DAG)
-
-
-
-
-
-
-

Dental Plan Selection

- Dental Low Option - No Ortho (EBA)
-

Vision Information

00130632

Vision Group Number

Who's covered?

- Self Only
- Self & Child(ren)
- Self & Spouse/Domestic Partner
- Family

Subgroup _____ Class _____

Vision Effective Date

Vision Plan Selection

- Vision Bronze Plan (VAD)
-

Section 2: Subscriber's Information

Last Name _____

Birthdate: _____

First Name _____

Gender:

- Male
- Female
- Gender X

Gender identity (optional):

- Transgender Male Prefer not to say
- Transgender Female Non-binary
- Prefer to self-describe: _____

Middle Initial _____ Title (e.g., Jr, Sr, III, etc.) _____

Social Security Number** _____

Street Address _____

Date of Hire/Rehire: _____

Retirement Date: _____

City _____

State _____

Subscriber's Medicare Number (if applicable)

Medicare Part A Effective Date _____ Medicare Part B Effective Date _____

Zip Code _____

Phone _____

- Age 65+ Disability
- End Stage Renal *

Section 3: Reason for enrollment or change **To be completed by the Group Administrator** **Not required for cancellations**

Enrollment Opportunity:	<input type="checkbox"/> New Hire	<input type="checkbox"/> Rehire	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Medicare eligible
Special Enrollment Opportunity:	<input type="checkbox"/> Newly Eligible Dependent: <input type="checkbox"/> Newborn <input type="checkbox"/> Marriage <input type="checkbox"/> Other _____			
<input type="checkbox"/> Change in employment status	<input type="checkbox"/> A move in or out of the service area			
<input type="checkbox"/> Involuntary loss of coverage	<input type="checkbox"/> Former dependent regains eligibility			
Date of Event _____, _____, _____				
COBRA Election - Please indicate the reason for COBRA if applicable:				
<input type="checkbox"/> Left Employment/Retired	<input type="checkbox"/> Divorce/Legal Separation	<input type="checkbox"/> Loss of Student Status	<input type="checkbox"/> Death of Spouse	
<input type="checkbox"/> Disability	<input type="checkbox"/> Dependent Reached Max Age <input type="checkbox"/> Other: _____			

Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?

Subscriber	Cancel Code:	Medical Cancel Date:	Dental Cancel Date:	Vision Cancel Date:	
Cancel Codes:	SB02-Left Employment	SB58-Change in Employee Eligibility Status	SB08-Subgroup Transfer*		
	SB06-Employee No Longer Wants Coverage* (subscriber request)	SB57- Layoff Without Benefits		* = Not eligible for COBRA	
	SB07-Deceased	SB09-Enrolled in Error*	SB44-Medicare Eligible (Moved to Medicare plan with same employer)		
Dependent(s)	Name:	Cancel Code:	Medical Cancel Date:	Dental Cancel Date:	Vision Cancel Date:
* = Not eligible for COBRA					
Cancel Codes:	M002-Deceased*	M005-Divorced	M010-Overage Dependent	M014-YA No Longer Qualifies*	M013-Ineligible Dependent
	M003-Subscriber No Longer Wants to Cover Dependent*			M007-Dependent No Longer Wants Coverage*	M009-Marriage
	M011-No Longer a Student	M004-Enrolled in Error*		M008-Moved Out of Area*	M040-Medicare Same Group*

Section 5: Information about who you would like coverage for (dependent information)

Spouse Domestic Partner Dependent Child Disabled Dependent Child (Separate application form required)
 Other _____

Last Name (if different)	Title	First Name	MI	Social Security Number **
Birthdate _____, _____, _____				
Gender: <input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Gender X	<input type="checkbox"/> Transgender Female <input type="checkbox"/> Non-binary <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Prefer to self-describe: _____	
Gender identity (optional): <input type="checkbox"/> Transgender Male				
Is dependent a full-time student over age 19? <input type="checkbox"/> Yes <input type="checkbox"/> No		Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Expected Graduation Date: _____, _____, _____	
If yes, please provide name of college/university _____				
Will dependent further education after graduation? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Medicare Eligible <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, indicate reason <input type="checkbox"/> Age 65+	<input type="checkbox"/> Disability	<input type="checkbox"/> End Stage Renal *
		Part A Effective Date: _____, _____, _____	Part B Effective Date: _____, _____, _____	
Medicare Number (if applicable) _____				

↓ Additional Dependent(s) ↓

<input type="checkbox"/> Dependent Child	<input type="checkbox"/> Disabled Dependent Child (Separate application form required)	<input type="checkbox"/> Other _____		
Last Name (if different)	Title	First Name	MI	Social Security Number **
Birthdate _____, _____, _____				
Gender: <input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Gender X	<input type="checkbox"/> Transgender Female <input type="checkbox"/> Non-binary <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Prefer to self-describe: _____	
Gender identity (optional): <input type="checkbox"/> Transgender Male				
Is dependent a full-time student over age 19? <input type="checkbox"/> Yes <input type="checkbox"/> No		Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Expected Graduation Date: _____, _____, _____	
If yes, please provide name of college/university _____				
Will dependent further education after graduation? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Medicare Eligible <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, indicate reason <input type="checkbox"/> Age 65+	<input type="checkbox"/> Disability	<input type="checkbox"/> End Stage Renal *
		Part A Effective Date: _____, _____, _____	Part B Effective Date: _____, _____, _____	
Medicare Number (if applicable) _____				

Dependent Child Disabled Dependent Child (Separate application form required) Other _____

Last Name (if different)	Title	First Name	MI	Social Security Number **
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X Gender identity (optional): <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Non-binary <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Prefer to self-describe: _____				
Is dependent a full-time student over age 19? <input type="checkbox"/> Yes <input type="checkbox"/> No		Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Expected Graduation Date: _____	
If yes, please provide name of college/university _____ Will dependent further education after graduation? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Medicare Eligible <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, indicate reason <input type="checkbox"/> Age 65+ <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal *	Part A Effective Date: _____ Part B Effective Date: _____	
Medicare Number (if applicable)				

Note: Use an additional application or addendum if more than three dependents need coverage

Section 6: Other coverage information (Required) - You may be contacted for additional information

Have you or any member of your family been enrolled in other medical or dental coverage? Yes No

If yes, what type of coverage? Medical Dental

What is the effective date of the other coverage? Medical: _____ Dental: _____

What is the name of the other carrier? _____

Are you keeping the coverage? Yes No

If no, when will the coverage end? Medical: _____ Dental: _____

Policyholder's name _____ ID#(s) _____

Who did the insurance cover? Self Only Self & Spouse/Domestic Partner Self & Child(ren) Family

Section 7: Release - You must sign and date this form to be eligible for health insurance

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who accepts coverage under the terms of the contract applicable to my coverage (who may include, for example my spouse and my eligible family dependents).

I hereby accept responsibility for payment of any portion of the premium.

I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Pediatric dental is an essential health benefit mandated by the ACA. If your employer group does not provide pediatric dental coverage through this Univera Healthcare plan, you agree to enroll in the dental plan offered to you by your employer.

EXCLUSIVE PROVIDER ORGANIZATION (EPO) I understand that if I elect Exclusive Provider Organization (EPO) coverage, except in an emergency, all care must be provided by medical providers who participate with the EPO and I will not receive benefits for care that I receive from providers who do not participate with the EPO.

HEALTH MAINTENANCE ORGANIZATION (HMO) I understand that I have elected a Health Maintenance Organization (HMO) plan and that I am required to choose a Primary Care Provider (PCP) who will provide my primary care, oversee my other health care services, and, when required, obtain prior approval for certain services such as Inpatient Facility care.

PREFERRED PROVIDER ORGANIZATION (PPO) I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and out-of-network benefit that provides coverage for services of medical providers who do not participate with the PPO.

I understand that the in-network benefit provides the highest level of coverage under the plan.

POINT OF SERVICE (POS) I understand that the Point of Service (POS) plan provides services on two benefit levels: in-network or out-of-network benefits. I understand that the in-network benefit provides the highest level of coverage under the plan and that I must choose a Primary Care Provider (PCP) to provide my primary care, oversee my other health care services, and, when required, obtain prior approval for certain services such as Inpatient Facility care.

I have thoroughly read, understand and agree to comply with the terms of the release in this section.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

Subscriber Signature _____ Date _____

Please return to P.O. Box 211256 Eagan, MN 55121-2656

If you have questions, please contact your Group Administrator. Or, visit us at: UniveraHealthcare.com

Instructions for completing the Group Health Insurance Application/Change Form

Section 1: Employer Group & Benefit Information

This section should be completed with your Group Administrator. Group Administrator's signature is required. Medical, dental and/or vision group numbers and information must be populated. Select who you need coverage for on the medical, dental and/or vision plan(s). Next, select the medical, dental and/or vision plan(s) you are enrolling in. All products may not be applicable to your employer group. Please check with your Group Administrator. Indicate the subscriber's status.

Section 2: Subscriber's Information

This section should be completed by the Subscriber. **We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act. * There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.

Gender and gender identity: Univera Healthcare does not discriminate on the basis of gender identity, gender expression or behavior. In order to ensure that you are receiving access to high quality, affordable health care based on your individual needs, we ask that you consider completing this **optional gender identity section** of the application. Univera Healthcare will not limit coverage or impose any additional cost-sharing for any otherwise-covered services that are ordinarily available to individuals of one sex, to a transgender individual, based on the fact that an individual's sex assigned at birth, gender identity, gender expression or behavior or gender otherwise recorded is different from the gender for which health care services are ordinarily available.

Section 3: Reason for enrollment or change

Select the box(es) that describe(s) the reason for this enrollment or change regarding health insurance coverage and include the date of the event. An event is a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request must be received within 30 days of the event date. Please see your Group Administrator for events that fall outside the 30-day period. You may be required to provide documentation of certain events.

Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?

If you are canceling coverage, complete the appropriate section for who you are canceling. List the cancel code and enter the date(s) the coverage is to be canceled. List each applicable dependent to be canceled.

Section 5: Information about who you would like coverage for (dependent information)

Please include information about all the people who you would like coverage for.

Use an additional application or addendum if more than three dependents need coverage.

If your dependents are Medicare eligible, complete the questions regarding Medicare coverage.

Qualified guidelines for coverage include:

- A legal spouse/domestic partner (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the county clerk)
- Must be under the eligible child age for your employer group including natural, adopted or stepchild(ren)
- Child(ren) Only coverage is available for children up to age 26 or 29 depending on the employer group coverage.
- There are additional eligibility requirements for dependents pending adoption, for which you are the legal guardian, and/or a disabled dependent who is over the maximum dependent age. Please contact your Group Administrator for the appropriate form.

**We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.

* There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.

A separate Adult Disabled Dependent application form is required for applicable dependents. Please contact your Group Administrator for the appropriate forms.

Section 6: Other coverage information (Required)

Please include accurate information in this section. This could affect the processing of your application and/or claims.

Section 7: Release

Subscriber signature and date are required in this section. The subscriber must sign the application prior to or within 30 days of the effective date or qualifying event date.