DeanHealthPlan
A member of SSM Health

Employee Application for Group Coverage

Applications must be received within 31 days of the eligibility date. Applications not completed in full will not be processed.

Employer Name:	Group Number:	Effective Date:
Employee Plan Selection:	Employee Class:	

Section A

1) Employee name (Last, First, Middle)

2) Street or Post Office address	3) City	4) County	5) State	6) Zip Code

7) Home phone number ( )	8) Work phone number ( )	9) Cell phone number ( )

10) Email address	11) How many hours on average do you work each week?

12) Are you: ☐ Single ☐ Married ☐ In a domestic partnership ☐ Divorced ☐ Legally separated ☐ Widow or widower Date of occurrence: _____	13) What was your first day of employment?	14) Are you a retiree? ☐ Yes ☐ No

15) Are you on COBRA or State Continuation? ☐ Yes ☐ No

If yes, provide start date and reason: _____

Section B

Please indicate reason for submitting application. *(Check appropriate box)*

- ☐ New Hire
- ☐ Loss of other coverage
- ☐ Late applicant
- ☐ Rehire
- ☐ Return from layoff
- ☐ Annual dual choice/open enrollment
- ☐ Transfer to disability segment
- ☐ Transfer to retiree segment
- ☐ Part-time to full-time employment or variable-hour employee eligible under ACA
- ☐ Election for continuation or COBRA

Effective date of change: _____

- ☐ Marriage
- ☐ Birth, adoption/placement for adoption
- ☐ Add/delete dependents
- ☐ Name change/address change/PCP change
- ☐ New Employer Group
- ☐ Other

Section C

Please select the type of insurance coverage for which you are applying.

☐ Employee only ☐ Employee and spouse/domestic partner ☐ Employee and dependent child(ren) ☐ Employee, spouse/domestic partner and dependent child(ren)

Name (Last, First Middle)	Relationship to Employee	Social Security Number	Date of Birth	Sex	Primary Care Provider or Clinic
	Self				
	Spouse/Domestic partner				
	☐ Child ☐ Stepchild ☐ Grandchild ☐ Other _____				
	☐ Child ☐ Stepchild ☐ Grandchild ☐ Other _____				
	☐ Child ☐ Stepchild ☐ Grandchild ☐ Other _____				
	☐ Child ☐ Stepchild ☐ Grandchild ☐ Other _____				

Section D

Does the dependent child(ren) named within this application live with you at the address shown above? If "no," please list the dependent child(ren)'s name and address(es):

☐ Yes ☐ No

If there is a stipulation in a legal decree or court order stating who is responsible for providing health insurance of the named dependent child(ren), please indicate the name of the person who has primary custody of the dependent child(ren) and the name of the responsible person for health insurance: _____

Do you, your spouse, or your dependent child(ren) listed in this application have current health insurance coverage or had previous health insurance coverage within the last 18 months? ☐ Yes ☐ No **If "yes," please complete the following table:**

Name (Last, First Middle)	Insurance Company, Plan & Group Number	Effective Date of Coverage	Termination Date of Coverage	Reason for Termination of Coverage	Type of Coverage

Section E

Are you or your spouse or child(ren) covered by Medicare Part A, Medicare Part B, or Medicare Part D? ☐ Yes ☐ No

If "yes," please list name(s): _____

Reason for Medicare: ☐ Age 65 ☐ Disability ☐ End Stage Renal Disease ☐ Disability and ESRD

Part A Effective Date: _____ Part B Effective Date: _____ Part C (Med Advantage) Effective Date: _____ Part D Effective Date: _____

Section F

I understand that I am eligible to apply for group health insurance through my employer. I do NOT want, and hereby waive, group health insurance for:

☐ Waiving for myself ☐ Waiving for my spouse/domestic partner ☐ Waiving for my dependent child(ren)

☐ Waiving for me, my spouse/domestic partner and my dependent child(ren)

Reason for waiver: ☐ Persons listed above have other insurance. ☐ Good health

☐ My earnings are such that I would have to pay more than 10% of my annualized gross earnings towards health insurance.

I understand and agree upon the terms/conditions listed on this application. A copy of this application is to be considered as valid as the original. I hereby authorize, on behalf of myself and my dependents, DHP/DHI to obtain or release medical information as set forth on the reverse side of this application. I certify that the plan benefits have been explained to me and/or I am fully aware that benefits may be reduced if I or an insured family member fails to follow any applicable requirements of the plan.

Employee Signature: _____ Date Signed: _____

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Terms and Conditions

1. By signing this Application, I understand and agree that: (a) all statements and answers I have given are complete and true to the best of my knowledge and belief; (b) the insurance I hereby apply for will be effective only when Dean Health Plan, Inc. (DHP)/Dean Health Insurance, Inc. (DHI) approves this Application. Evidence of such approval will be the issuance of ID Card(s), which will be delivered to the group or employee. The effective date will be the date shown on the I.D. card issued; (c) the Social Security numbers I have provided may be used for I.D. purposes; and (d) if me or my dependents health has changed from what is indicated on the Application prior to the effective date of coverage, I will notify DHP/DHI of the change immediately. Changes in medical history prior to the effective date of coverage, but not reported to DHP/DHI, will be considered misstatements. Any person who knowingly presents a false or fraudulent claim within the contestable period for payment of a loss or benefit or knowingly presents false information in an Application for insurance is guilty of a crime and may be subject to fines and/or imprisonment under Wis. Stat. 943.395. I further understand that, in the event of fraud or misrepresentation, this information may be used to reduce or deny a claim, void coverage, or void the group contracts within the contestable period, if such misrepresentation affects DHP/DHI's acceptance of risk.

2. By my signature on this application, I authorize: (a) Any physician, medical practitioner, hospital, clinic, medically related facility or other institution who provided treatment or service to me, my spouse or my minor child(ren) at any time, or their agent(s) (including billing service), having medical information which includes, but is not limited to, identification, medical history, diagnosis, prognosis, consultations, advice, treatments, services, dates of treatments and/or services, test results (excluding genetic tests and FDA-licensed blood tests for the presence of HIV, but including X-rays), summary reports, without limitation to period of treatment, diagnostic or therapeutic information, history or type of injury or illness (including pregnancy and treatment or service, if any, for mental or nervous conditions, alcohol abuse or drug abuse), and (b) Any insurance or reinsuring company, service or prepaid benefit plan, plan administrator, consumer reporting agency, employer or personal or business associates having non-medical information about me, my spouse, or my minor child(ren), concerning eligibility and claim administration to disclose to DHP/DHI, or their representatives (including the claims department) all such information. I understand that when used for obtaining information in connection with an insurance policy application, this Authorization is valid for 30 months. I understand that when used for the purposes of obtaining information in connection with claims for benefits, utilization review, quality improvement, health care operations or other activities as permitted by law, this Authorization is valid during the Policy term or pendency of the claims for benefits, which ever is longer. I understand that I may request and receive a copy of this authorization.

3. I understand that any approved coverage is not effective for me or my dependents if I am not actively at work at my full-time employment with my employer on the assigned effective date, but that such coverage will first become effective on the first day thereafter that I am actively working at such employment.

4. This Application, when approved, and any endorsement, amendment, or rider thereto, will be made part of the contract(s) applied for.

5. No person, except an officer of DHP/DHI, is authorized to vary or modify a contract. I further understand and agree that DHP/ DHI, its directors, officers, employees, and agents shall not be liable for any injury, damage, or expense (including attorney's fees) that I or any of my dependents suffer as a result of any improper advice, action, or omission on the part of any health care provider.

6. Subject to the acceptance of the Application by DHP/DHI, I authorize the group, as my remitting agent and until this authorization is revoked in writing, to deduct from my wages or salary a sufficient amount to provide for the regular and timely prepayment of the prevailing subscription fees that are not otherwise contributed by my employer for the contract(s) applied for and to remit the same on my behalf to DHP/DHI.

7. The contract(s) applied for will become void if and when I cease to be employed or affiliated with the group. Should I wish to retain my membership after such termination, it shall be my responsibility to secure a new application form from DHP/DHI and to apply for the programs then being offered to such individuals.

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