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.

If you are waiving, fill out Waiver form and submit to HR by 11/14/19. available on intranet or through Human Resources x5520

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: _____