

APPLICATION INSTRUCTIONS:

- 1 This application must be completed by the applicant for himself/herself and all eligible dependents.
 - Group Plan Administrator may complete an employee application on behalf of the employee per the following criteria:
 - i. The employee is court ordered to provide coverage for a dependent, or
 - ii. The Group Plan Administrator wishes to add or terminate employees and/or dependents through the Cox HealthPlans online Administrator access.
 - The Group Plan Administrator may NOT complete an enrollment form on behalf of an employee when medical information is required for underwriting purposes.
- 2 Please print using a ball point pen and complete all questions.
- 3 Be sure to sign and date where indicated and on any additional pages you may include.

Incomplete or forms completed in pencil will be returned and may delay coverage.

SECTION A: APPLICANT INFORMATION

1	LEGAL NAME (Last, First, MI)	SOCIAL SECURITY #:	BIRTH DATE:	GENDER: M F	HEIGHT:	WEIGHT:
	CURRENT ADDRESS:	HOME PHONE:	WORK PHONE:	CELL PHONE:		
	CITY:	COUNTY:	STATE:	ZIP:	USE TOBACCO: Y N	
2	MARITAL STATUS (Select One): <input type="checkbox"/> SINGLE/DIVORCED/WIDOWED <input type="checkbox"/> MARRIED	GROUP/COMPANY/EMPLOYER NAME: CI564S OZARK R-VI SCHOOL DISTRICT	OCCUPATION:	DATE OF HIRE:		

SECTION B: REASON FOR APPLICATION *Note: If waiving coverage, please check and skip to Section I)*

1	<input type="checkbox"/> New Subscriber <input type="checkbox"/> Add Dependents (List below) <input type="checkbox"/> Terminate Dependents (List below) <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change	<input type="checkbox"/> Retiree <input type="checkbox"/> COBRA / State Continuation: Continuation Start date: _____ <input type="checkbox"/> Special Enrollment: Qualifying Event Type: _____ Qualifying Event Date: _____
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SECTION C: PRODUCT & COVERAGE SELECTION

1	PRODUCT: <input type="checkbox"/> PPO - Cox Health Systems Insurance If dual option, indicate plan: _____
2	COVERAGE: <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> EMPLOYEE & SPOUSE <input type="checkbox"/> EMPLOYEE & CHILD(REN) <input type="checkbox"/> EMPLOYEE & FAMILY

SECTION D: DEPENDENT INFORMATION (If additional space is needed, back of page 1 may be used.)

ENROLL/ CHANGE/TERM	LEGAL NAME (Last, First, MI)	RELATIONSHIP	SOCIAL SECURITY #	GENDER	BIRTH DATE (mm/dd/yy)	HEIGHT	WEIGHT	USE TOBACCO
				M F				Y N
				M F				Y N
				M F				Y N
				M F				Y N
				M F				Y N
				M F				Y N

SECTION H: TERMS, CONDITIONS, AUTHORIZATIONS, AND OTHER PROVISIONS

1	I declare that I am an employee regularly scheduled to work full time (as defined by employer), year round, for full pay, at my employer's normal place of work and in the employer's normal business and request to be insured.
2	<p>Authorization: I authorize any physician, hospital, clinic, other medical or medically related facility, or insurance company to release to Cox Health Systems Insurance Company ("CHSIC"), its legal representatives or its reinsurers, any information, record or knowledge of the health of any persons proposed for insurance for determination of claims. This consent includes information about drug and alcohol use. I authorize any consumer reporting agency that has any record, public record or knowledge of any persons proposed for insurance to give to CHSIC, its legal representatives or reinsurers, any such record or knowledge for purposes of underwriting insurance. A photographic copy of this consent shall be as valid as the original.</p> <p>I understand that I may revoke this authorization for information by supplying the revocation in writing to the Home Office of CHSIC. I understand that the revocation will not be in effect until it is received at the Home Office. Unless revoked, I agree that, when signed in connection with an application for, reinstatement of, or request for change in benefits, this form shall be valid for two years after the date shown below.</p>
3	<p>Representation: I hereby declare I have read, or had read to me, the questions and responses on this application. I represent that all information, statements, and answers made on this form, and any attachments, about myself or any dependents' state of health, are complete and true to the best of my knowledge. I understand that they shall be a part of this request for coverage under the group's policy. I realize any false statements, omissions and/or material misrepresentations regarding any information requested on this form, could cause an otherwise valid claim to be denied and/or cause the insurance coverage, if issued, to be cancelled as never effective. For any applicant listed on this form, after coverage has been in effect for two (2) years, no statement will void the coverage or reduce the benefits, unless the statement was material to the risk assumed, fraudulent, and contained on this form.</p> <p>NOTICE: Any person who, knowingly or with intent to defraud any insurance company or other person, files an application of 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 subjects such person to criminal and civil penalties.</p>
4	<p>Pre-Existing Conditions: A Pre-Existing Condition exclusion may apply to any employee or dependent enrolling in a CHSIC PPO health plan. This exclusion can apply only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a pre-existing condition exclusion cannot last for more than twelve (12) months after your enrollment date. Finally, a pre-existing condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within thirty-one (31) days after birth, adoption, or placement for adoption.</p> <p>The Pre-Existing Condition exclusion may be waived if the employee or dependent was covered by a prior qualifying plan in certain situations. These provisions will be described in the Evidence of Coverage issued to the employee and will never be more restrictive than the applicable state and federal law.</p>
5	Important Information: I understand no coverage under this insurance exists unless and until approved by Cox Health Systems Insurance Company, Inc. at its home office in Springfield, Missouri. If at any time prior to such approval, anyone applying for coverage under this application consults a doctor, is hospitalized, or has any change in health, I agree to inform CHSIC and understand that I am responsible for all charges incurred.
6	I understand that no producer, agent, or broker may change or waive any rates, benefits, or provisions of the policy, if issued, without the written approval of an officer of CHSIC.

SIGNATURE REQUIRED	<div style="font-size: 2em; font-weight: bold; margin-bottom: 5px;">X</div> <hr style="border: 0; border-top: 1px solid black;"/>	<hr style="border: 0; border-top: 1px solid black;"/>
	Signature of Enrolling Employee*	Date Signed
	* A Group Plan Administrator may sign on behalf of the employee under certain circumstances. Please refer to the "Application Instructions" section for more details.	

SECTION I: WAIVER OF COVERAGE (If you are waiving coverage for any reason, including other coverage, you must complete this section, Section A, read Section H, then sign and date this form.)

1	<p>I am declining coverage for:</p> <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child(ren) <input type="checkbox"/> Myself and all dependents	<p>Declining coverage due to existence of other coverage:</p> <input type="checkbox"/> COBRA or State Continuation * <input type="checkbox"/> Medicaid <input type="checkbox"/> Coverage under Spouse's group plan * <input type="checkbox"/> Medicare or Champus (Tri-Care) <input type="checkbox"/> Individual Health Plan * <input type="checkbox"/> Other: _____ <input type="checkbox"/> I (we) have no other coverage at this time
2	<p>* If you are waiving due to other coverage, you must provide a copy of your insurance card or list your information below: Insurance Company Name: _____ Policy #: _____</p> <p>Waiving Coverage: If you are declining enrollment for you or your dependents, you must wait until the next open enrollment period for your group to enroll unless you meet the special enrollment rules described below: Rule #1: Eligibility for coverage under other employer sponsored group health plan ends; except for failure to pay premiums or termination for cause. Rule #2: Loss of coverage as a result of exhaustion of COBRA benefits, eligibility for coverage including legal separation, divorce, death, termination of employment, reduction of hours, or your employer contributions for coverage were terminated. Rule #3: Newly acquired dependent as a result of marriage, birth, adoption, or placement for adoption, and a court or administrative order stating the employee shall provide insurance for dependent child(ren). The eligible covered employee or dependent will have a special enrollment period of thirty-one (31) days within which to submit the required forms to enroll, that begins on the date of the qualifying event.</p>	
	<div style="font-size: 2em; font-weight: bold; margin-bottom: 5px;">X</div> <hr style="border: 0; border-top: 1px solid black;"/>	<hr style="border: 0; border-top: 1px solid black;"/>
	Signature of Employee Waiving Coverage (sign only if waiving coverage)	Date Signed