

# Employee Application for Group Health Insurance PPO 51+

Cox Health Systems Insurance Company  
3200 South National, Building B • Springfield, Missouri 65807 • (417) 269-4679



## 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 ballpoint 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: <b>M F</b>	Height:	Weight:
Current Address:			County:		Use Tobacco: <b>Y N</b>
City:			State:	Zip:	
Work Phone:	Home/Cell Phone:	Preferred Language:		Ethnicity:	
2 Marital Status (Select One): <input type="checkbox"/> Single/Divorced/Widowed <input type="checkbox"/> Married		Group/Company/Employer Name:	Occupation:	Date of Hire:	

## Section B: Reason for Application (Note: If waiving coverage, please check and skip to Section J)

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"/> Plan 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 and Coverage Selection

1	<b>Product:</b> <input type="checkbox"/> PPO-Cox Health Systems Insurance If dual option, indicate plan: _____
2	<b>Coverage:</b> <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
				<b>M F</b>				<b>Y N</b>
				<b>M F</b>				<b>Y N</b>
				<b>M F</b>				<b>Y N</b>
				<b>M F</b>				<b>Y N</b>
				<b>M F</b>				<b>Y N</b>
				<b>M F</b>				<b>Y N</b>
				<b>M F</b>				<b>Y N</b>
				<b>M F</b>				<b>Y N</b>
				<b>M F</b>				<b>Y N</b>

**Section E: Health Information** *(This information is only required for underwriting purposes.)*

- 1 Have you, or any of your dependents, had medical expenses in excess of \$5,000, or received inpatient or outpatient hospital care within the last 12 months? *(If yes, please complete Section F)*  Yes\*  No
- 2 Are you, or any of your dependents, currently disabled? *(If yes, please complete Section F)*  Yes\*  No
- 3 Are there any conditions diagnosed or treated in the last five years?  Yes\*  No
- 4 In the last five years, have you had any abnormal test or physical results, tests/treatment/surgery advised, pending test results, referral to a specialist or condition?  Yes\*  No
- 5 Do you, or any of your dependents, take any medicine(s), drugs or pills or require shots?  Yes\*  No

6 Within the last 10 years, have you, or any dependent listed on this application, ever been diagnosed with, or treated for, any conditions of the body systems listed below:

**None of the conditions listed below**

**Brain/Nervous**

- Alzheimer's
- Cerebral Palsy
- Headaches
- Migraines
- Multiple Sclerosis
- Paralysis
- Parkinson's
- Seizures/Epilepsy
- Other: \_\_\_\_\_

**Bones/Muscular**

- Arthritis
- Rheumatoid Arthritis
- Osteoporosis
- Lupus
- Back/Neck Pain or Disorders
- Bulging/Herniated Disk
- Joint Pain
- Muscular Dystrophy
- Other: \_\_\_\_\_

**Cancer/Tumor**

- Brain
- Breast
- Colon
- Leukemia
- Liver
- Lung
- Lymphoma
- Melanoma
- Prostate
- Skin
- Uterine/Cervical/Ovarian
- Other: \_\_\_\_\_

**Digestive**

- Crohn's
- Gallbladder
- Gastric/Peptic Ulcer
- Hernia  
Type: \_\_\_\_\_
- Liver Disorder
- Cirrhosis
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Irritable Bowel/Colon Disorder
- Pancreatitis
- Reflux/GERD
- Ulcerative Colitis
- Weight Loss Surgery
- Other: \_\_\_\_\_

**Endocrine/Metabolic**

- Diabetes  
Type I or Type II  
Last A1C Reading: \_\_\_\_\_
- Thyroid
- Other: \_\_\_\_\_

**Eyes/Ears/Nose/Throat**

- Allergies
- Cataracts
- Glaucoma
- Retinopathy
- Other: \_\_\_\_\_

**Heart/Circulatory**

- Aneurysm
- Angioplasty/Stent
- Bypass

**Congestive Heart Failure**

- Elevated Cholesterol
- Heart Attack  
Date: \_\_\_\_\_
- Heart Disease
- Heart Murmur
- Heart Valve
- High Blood Pressure
- Irregular Heartbeat
- Stroke
- Other: \_\_\_\_\_

**Immune/Blood Disorder**

- AIDS/HIV
- Anemia
- Lupus
- Other: \_\_\_\_\_

**Lung/Respiratory**

- Asthma
- Chronic Bronchitis
- COPD
- Emphysema
- Pneumonia
- Sleep Apnea
- Tuberculosis
- Other: \_\_\_\_\_

**Mental Health/Substance Abuse**

- Alcoholism
- Anxiety/Depression
- Attention Deficit Disorder
- Bipolar/Manic Depression
- Drug Abuse/Illegal Drug Use
- Eating Disorder
- Inpatient/Residential Treatment
- Other: \_\_\_\_\_

**Reproductive**

- Abnormal Pap  
Date of last abnormal: \_\_\_\_\_  
Treatment: \_\_\_\_\_
- Abnormal Uterine Bleeding
- Breast Disorder
- Current Pregnancy  
Due Date: \_\_\_\_\_
- Past/Current Complications
- Multiples Expected
- Previous C-Section
- Endometriosis
- HPV/Condyloma
- Ovarian Conditions
- Sexually Transmitted Disease
- Uterine Fibroids
- Other: \_\_\_\_\_

**Transplant**

- Past Transplant(s)  
Organ: \_\_\_\_\_
- Possible Future Transplant(s)  
Organ: \_\_\_\_\_

**Urinary/Kidney**

- Kidney Stones
- Polycystic Kidney Disease
- Prostate Disorder
- Renal Failure
- Bladder Disorder
- Other: \_\_\_\_\_

**Other conditions/treatments not listed:**  
\_\_\_\_\_  
\_\_\_\_\_

**\*IF YES INDICATED TO ANY OF THE CONDITIONS LISTED ABOVE, PLEASE COMPLETE SECTION F**

**Section F: Health Information Continued** *(Please provide full details for any conditions checked or questions answered "Yes" in Section E above. Use additional paper if necessary. Please sign and date all pages.)*

Legal Name (Last, First, MI)	Diagnosis/Condition	Date Last Treated or Indicate "Ongoing"	Treatment Received/Expected to Receive

**Section G: Medication Information** *(Please provide full details for any medications currently taken)*

Legal Name (Last, First, MI)	Diagnosis/Condition	Name of Medication	Start Date	Frequency	Dosage

## 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 **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 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. A photographic copy of this consent shall be valid as the original.  
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 (2) years after the date shown below.
- 3 **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 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.  
**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.
- 4 **Important Information:** I understand no coverage under this insurance exists unless and until approved by CHSIC 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.
- 5 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

X

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: Electronic Consent (optional)

- 1 I understand and consent to receiving plan documents or notices delivered by electronic means. I understand I have the right to delivery of these documents or notices in paper form at no additional cost upon request. I understand I have the right to withdraw consent to have these documents or notices delivered by electronic means upon verbal request to Cox HealthPlans, LLC by contacting the Member Service Department. These documents are always available on the Member Portal located on our website at [www.coxhealthplans.com](http://www.coxhealthplans.com) or by calling 800-205-7665 for the information to be mailed. Electronic delivery will require e-mail and Internet capability.

Please initial and clearly print your e-mail address: \_\_\_\_\_ Initial Here: \_\_\_\_\_

## Section J: 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 **I am declining coverage for:**
- Myself
  - Spouse
  - Dependent Child(ren)
  - Myself and all dependents
- Declining coverage due to existence of other coverage:**
- COBRA or State Continuation\*
  - Coverage under Spouse's group plan\*
  - Individual Health Plan\*
  - I (we) have no other coverage at this time
  - Medicaid
  - Medicare or CHAMPUS (Tri-Care)
  - Other: \_\_\_\_\_

- 2 \*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 #: \_\_\_\_\_

**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 of 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 31 days within which to submit the required forms to enroll, that begins on the date of the qualifying event.

X

Signature of Enrolling Employee (sign only if waiving coverage)

Date Signed