Appendix B

COLORADO UNIFORM EMPLOYEE APPLICATION FOR **SMALL GROUP** HEALTH BENEFIT PLANS

This form is designed for an employee's initial application for coverage. Please contact your agent or the carrier to determine if this form should be used in other situations once the group is enrolled with the carrier.

COVERAGE INFORMATION

Application Type:	☐ New Coverage	☐ Change/Modification to Existing Policy	☐ Open Enrollment	☐ Special Enrollment*

Special Enrollment Period Qualifying event:
☐ Loss of Coverage ☐ Birth/Adoption/Placement for Adoption ☐ Marriage ☐ Other:_____ Date of Event:_____

* Proof of eligibility for special enrollment will be required – information on special enrollment periods is available at: https://www.colorado.gov/pacific/dora/division-insurance

EMPLOYER INFORMATION

Employee Name:		Employer Name:	
Proposed Effective Date:		Group Number (if known):	

EMPLOYEE INFORMATION

Employee Instructions: Please type or print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought.

First Name:		Middle Initial:		Last Name:	

SSN/TIN/ALT ID #: Not filing out this field shall not be a reason to deny an application for coverage		Date of Birth:	/ /	Current Age:	Gender: ☐ M ☐ F ☐ X

Physical Address:		City:	
County:	State:	Zip:	
Mailing Address (If different, can be P.O. Box):		City:	
County:	State:	Zip:	
Home Phone:	Alternate Phone:	Email:	Home / Work
First day of employment?	How many hours, on average, do you work each week?	Work Phone:	

Are you (check one): ☐ Single ☐ Married ☐ Civil Union ☐ Legally Separated ☐ Divorced ☐ Designated Beneficiary ☐ Widow/Widower
☐ Common Law ☐ Designated Beneficiary - A common law or designated beneficiary certification may be required by the carrier

Are you on COBRA or State Continuation?	☐ Yes	☐ No	Start Date:		Stop Date:	

It should be noted that American Indians and Alaskan Natives have an enhanced ability to enroll in individual health benefit plans under the Affordable Care Act.

Tell us about your race. *This information is confidential and will only be used to help us improve service to all Coloradans. We use this information to make sure everyone gets fair access to coverage. Providing this information will not impact eligibility, plan options, or costs.*

What is your race? (Select all that apply) *(optional)*
☐ American Indian/Alaskan Native ☐ Asian/Asian American ☐ Black/African American ☐ Hispanic/Latino ☐ Middle Eastern/North African
☐ Native Hawaiian/Pacific Islander ☐ White/European ☐ Not Listed or Other: _____ ☐ Prefer not to answer

TYPE OF HEALTH COVERAGE

List all dependents (spouse/partner and child(ren)) applying for coverage. If you need additional space, please use a separate sheet of paper and attach it to this application (please print your name and sign and date the additional sheet).

Please select the type of health insurance coverage for which you are applying:	☐ Employee Only	☐ Employee & Spouse	☐ Employee & Child	☐ Employee & Family

Name of plan selected: _____

Dependent Information- List all dependents to be covered

Name (First, MI, Last)	SSN/TIN/ALT ID # (can leave blank):	Gender	Relationship	Disability Y/N	Birth Date (MM/DD/YY)
		☐ M ☐ F ☐ X	SPOUSE/PARTNER ☐ ☐	☐ Yes ☐ No	

		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	

Employee Name:	Employer Name:

TOBACCO USE
Please answer the following questions to the best of your knowledge. 45 CFR 147.102(a)(1)(iv) "For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used." Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months? If yes, provide the information requested below.

Name of Person	Used Tobacco Products
	☐ Yes ☐ No
	☐ Yes ☐ No

EMPLOYEE/DEPENDENT WAIVER OF COVERAGE

Complete this section ONLY if you are not enrolling yourself or your spouse/partner or dependents. Waiver must be completed for all of your dependents to be eligible for enrollment on this plan in the event of changing circumstances. I understand that I am eligible to apply for group health coverage through my employer. I do NOT want, and hereby waive, group health coverage for:

	Name (Last, First, MI)	Birth Date (Mo/Day/Year)
Employee		
Spouse/Partner		
Dependent 1		
Dependent 2		
Dependent 3		
Dependent 4		
Dependent 5		
Dependent 6		

I am waiving group health coverage for myself and/or the dependents listed above because (check all that apply, copy of ID card may be required):	
☐	I am covered under my spouse/partner's group policy
☐	My spouse/partner is covered under another plan (including this plan, if spouse/partner is also an employee)
☐	My dependents are covered under another plan
☐	I wish to continue other coverage obtained through an Individual Plan or Medicare
Other (Please explain):	

WAIVER: I certify that I have been given the opportunity to apply for group health coverage and decline to enroll as indicated above, on behalf of myself, my spouse/partner and my dependent child(ren). I understand that by signing this waiver, I, my spouse/partner, and my dependent child(ren) forfeit the right to coverage. I was not pressured, forced or unfairly induced by my employer, the agent or the carrier(s) into waiving or declining the group health coverage. If in the future I apply for coverage, I, my spouse/partner, or any of my dependent child(ren) may be treated as a late enrollee and subject to postponement of coverage for up to 12 months.

I understand that if I am declining enrollment for myself, my spouse/partner, or my dependent child(ren) because of other health coverage, I may, in the future, be able to enroll myself, my spouse/partner, or my dependent child(ren) in this plan, as required by law, provided that I request enrollment within

30 days after my other health coverage ends or a qualifying event occurs. If I do not request enrollment within 30 days of the above events, I understand that I may not be able to enroll for coverage until my company's Open Enrollment period. I understand that I can obtain information related to my enrollment eligibility from my employer or small group health carrier.

Signature of Employee:_____ Date Signed:_____

Employee Name:	Employer Name:

MEDICARE INFORMATION

If you need to complete this section for more than one person, please use a separate sheet of paper and attach it to this application (please sign and date the additional sheet). A copy of your ID card may be required.

Are you, your spouse/partner or your child(ren) covered by:

Medicare Part A?	☐ Yes	☐ No	Medicare Part B?	☐ Yes	☐ No	Medicare Part D?	☐ Yes	☐ No

If "Yes," reason for Medicare:	☐ 65+	Effective Date:	☐ Disability	Effective Date:
	☐ End-stage Renal Disease (ESRD)	Effective Date:	☐ Disability and ESRD	Effective Date:

Name of person covered by Medicare:

CURRENT MEDICAL COVERAGE

Will you, your spouse/partner, or your dependent child(ren) listed in this application have other health insurance coverage that will be in effect at the same time as the coverage you are applying for on this application? ☐ Yes ☐ No

Your information will help the small employer carrier(s) to coordinate benefits with any other group health coverage you may have.

Name	Carrier Name Carrier Phone Number	Plan Name Group Number Subscriber ID#	Effective Date of Coverage (MM/DD/YY)	Termination Date of Coverage (MM/DD/YY)	Type of Coverage (See Key Below)

Type of Coverage Key: G = Group Comprehensive Major Medical; I = Individual Comprehensive Major Medical; MS = Medicare Supplement; H = Hospital Coverage Only; V = Vision Coverage Only; D = Dental Coverage Only O=Other, please explain:_____

This is being asked to determine if there will be coordination of benefits if any of the individuals on the application have existing coverage

PRIMARY CARE PHYSICIAN SELECTION, IF APPLICABLE

This section should be completed only if the small employer group insurance for which you are applying requires the selection of a primary care provider. A selection should be made for each individual applying for such coverage. The provider information may be listed in the provider materials that are supplied by each carrier to your employer. Use additional sheets if necessary.

Covered Person's Name	Medical Plan	Primary Care Physician Name:	Primary Care Physician Address: (optional)	Is this your current provider?

Employee Name:	Employer Name:

CERTIFICATION OF DENTAL INSURANCE COVERAGE Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado or for consumers without children under the age of nineteen (19)	
Pediatric dental coverage is a required essential health benefit. The plan you select may not include pediatric dental coverage. Do you have pediatric dental coverage under another plan?	☐ Yes ☐ No Note: you may be required to provide proof that you have obtained coverage before this policy will be approved

TERMS – CONDITIONS- DISCLOSURES

I acknowledge that I have read all sections of this Colorado Uniform Employee Application for Small Employer Group Health Coverage (Application), and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge. I understand and agree that neither my employer nor any insurance agents have any authority to waive my complete answer to any question, agree to insurability, alter any contract, or waive any Colorado small employer carrier's other rights or requirements.

I hereby apply for enrollment for myself and for my eligible family dependents listed. On behalf of my eligible family dependents and myself, I agree to all of the terms and conditions of the group contract(s) with Colorado small employer carrier(s) under which I wish to enroll for coverage. I have indicated in this Application, if required, what product(s) or provider(s) I have selected. I agree that no coverage will be effective until the date specified by the Colorado small employer carrier(s) with whom I enroll, after this application has been accepted by such carrier(s).

I understand and agree that any information obtained in connection with this Application will be used by Colorado small employer carrier(s) to determine eligibility for coverage.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

When applicable, I authorize my employer to deduct contributions from my earnings to be applied to the cost of coverage.

I agree to any applicable group contract provisions for the resolution of disagreements and disputes, including arbitration when required and as allowed by law. Please refer to any arbitration provisions in the group contract(s).

I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document will become a part of the contract when coverage is approved and issued.

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY APPLICABLE HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO ANY SMALL EMPLOYER THAT APPLIES FOR THE PLAN AND AGREES TO MAKE THE REQUIRED PREMIUM PAYMENTS, AND SATISFIES THE OTHER PROVISIONS OF THE HEALTH BENEFIT PLAN.

This document is a publication of the Colorado Division of Insurance. If you have questions about the content of this document please contact our offices at 303-894-7499 or visit our website at https://www.colorado.gov/pacific/dora/division-insurance. For questions regarding coverage or enrollment please see your employer.

Signature of Employee:_____ Date Signed:_____