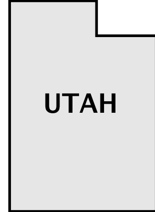
10421 South Jordan Gateway
Suite 400
South Jordan, UT 84095

SMALL GROUP (2-50) ENROLLMENT FORM

HMO:	Plus (POS):	Health Suite:
☐ Peak	☐ Peak Plus	☐ Peak Plus
☐ Peak Traditional	☐ Peak Plus Extended	☐ Peak High
☐ Peak QHDHP	☐ Peak Advantage	☐ Peak Low
☐ Peak Advantage	☐ Peak Plus QHDHP	☐ Peak Traditional
		☐Dental ☐ Other

For Office Use Only
Group No. ___________
Effective Date _______________
PEC: _______________
____
New Hire Waiting Period _______________



A. - EMPLOYER INFORMATION

Employer: _________________________ Hire Date: _________ Rehire Date: __________

Location: ______________________________________ Is this a division? ☐Yes* ☐No

*If "Yes," Name of parent company: ____

Coverage	Self	Spouse	Child(ren)	COBRA	State Cont. Coverage	EFFECTIVE DATE
Medical	☐	☐	☐	☐	☐	_________
Dental	☐	☐	☐	☐	☐	_________

B. - EMPLOYEE

❖ **All Plans:** If covering dependent(s) due to court order, attach copy of court documentation. Please note address and telephone number, if different from subscriber's: ____

Name Last: ________________________ First: ____________________ MI: ____ Job Title: ________________________ Hours per Week: _______

Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Widowed E-Mail Address: ____

Address: ______________________________________ Apt. #: ________ City: _____________________ State: _________ Zip Code: ___________

Home Phone: (______) ___________________________ Business Phone: (______) ______________________________

Spouse's Employer: ________________________________ Spouse's Business Phone: (______) ______________________

C. - OTHER HEALTH COVERAGE (in addition to Altius) *fully complete sections C and E*

Do you or your dependent(s) have other health insurance *in addition to Altius?*

☐ No *(go to D.)* ☐ Yes – what coverage? ☐ Medical ____________________ (Name of carrier) ☐ Rx ☐ Medicare* Other Carrier's Phone: (____) _________

Policyholder's Name: ____________________________ Policy # __________________ Effective date of coverage: _____________

*If other coverage is Medicare or Medicaid, are you or any of your dependents disabled?

☐ No ☐ Yes – Indicate name(s) ____

If this coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care insurance so that Altius can determine whose coverage is Primary.

D. - PRIOR HEALTH COVERAGE (before Altius) *fully complete sections D and E*

Have you or your dependent(s) had health insurance *prior to Altius?*

☐ No *(go to E.)* ☐ Yes** – what coverage? ☐ Medical ____________________ (Name of carrier) ☐ Rx ☐ Medicare Prior Carrier's Phone: (______) ____________

When was the last date that you were insured? ______________________ Effective date of coverage: ____________________

Term Date: ____________________ Policyholder's Name: ____________________________ Policy # ______________________

***Note: If you have had health care coverage within the last 63 days, your Pre-Existing Condition (PEC) waiting period limitation may be partially or completely waived. To determine if this applies to you, you must provide proof of prior coverage, such as a Certificate of Creditable Coverage from your previous carrier.*

Submission of prior coverage information does not automatically waive any Pre-Existing Condition Limitation. However, you will be subject to an automatic Pre-Existing Condition Waiting Period of up to 12 months until we receive evidence of prior coverage.

E. - SUBSCRIBER/SPOUSE/DEPENDENTS ˘ attach separate sheet if necessary

	Social Security #	Office use only	Name - Last	First	MI	Date of Birth	Age	M/F	Other Coverage (circle all that apply) Medical	Rx	Medicare
self									Y or N	Y or N	A, A&B, D
spouse									Y or N	Y or N	A, A&B, D
dependents									Y or N	Y or N	A, A&B, D
dependents									Y or N	Y or N	A, A&B, D
dependents									Y or N	Y or N	A, A&B, D
dependents									Y or N	Y or N	A, A&B, D

Note: Did you fill in Social Security Number? IMPORTANT: INCOMPLETE INFORMATION WILL DELAY ENROLLMENT. If you have any questions regarding this enrollment application, please call the Customer Service office at 323-6200, or toll free at 800-377-4161.

F. - HEALTH HISTORY

Instructions: Answer each question for each individual applying for coverage. Circle the specific item and check the appropriate box for each question. For each "Yes" answer, give complete and specific details in section G.

CURRENT HEALTH

	Yes	No
1. Has anyone been under medical care in the last 12 months?	☐	☐
2. Has anyone consulted, been tested, or had treatment by a doctor, chiropractor, counselor, therapist, or other health care provider within the past three years?	☐	☐
3. Is any family member currently pregnant or have reason to suspect that they might be pregnant?	☐	☐
4. Are you or your spouse financially responsible for an unborn child, or anticipating adoption within the next 12 months?	☐	☐
5. Does anyone have a health problem for which they have not sought medical advice or treatment in the last 12 months?	☐	☐
6. Do you have a spouse or dependent(s) who are not applying for coverage? If yes, complete (a) and (b) below. *(Please refer to Section I)*	☐	☐

a. List the reason(s) why your spouse and/or dependents are not applying for coverage on this plan. ____________________

____

b. Current health status of those not applying for coverage.

____

	Yes	No
7. Has anyone used tobacco in the last 12 months?	☐	☐
8. Has anyone taken any medication, drugs, or shots in the past 12 months? If yes, complete section H.	☐	☐

5-YEAR HEALTH HISTORY

9. Within the past 5 years, has any proposed insured been diagnosed, treated, or had any of the following conditions:

	Yes	No
a. Advised to be hospitalized, have tests, have surgery or take medication, but has not done so?	☐	☐
b. Fertility. Is anyone infertile, had miscarriages, or complications of pregnancy?	☐	☐
c. Ulcers, hernia, chronic diarrhea or other digestive problems?	☐	☐
d. Urinary problems or urinary incontinence?	☐	☐
e. Irregular bleeding, abnormal pap smears, pelvic inflammatory disease, endometriosis, prostate or testicular problems, venereal disease or any disorder of the reproductive system?	☐	☐
f. Unconsciousness, epilepsy, seizures, or convulsions?	☐	☐
g. Mental health counseling, psychotherapy, had a mental or nervous disorder, depression, stress or anxiety that interfered with daily life?	☐	☐
h. Cysts, growths (except warts), breast lump(s), breast augmentation or reduction?	☐	☐
i. Skin disorder that required medical attention?	☐	☐
j. Thyroid disorder, disorder of the lymph nodes, or lymph system?	☐	☐
k. Chest pain, high blood pressure, or high cholesterol?	☐	☐
l. Disorder of the eyes, ears, nose, or throat?	☐	☐
m. Back, neck, spinal problems, or a joint disorder that required medical attention and/or interfered with daily functioning?	☐	☐

10-YEAR HEALTH HISTORY

10. Within the past 10 years, has any proposed insured been diagnosed, treated, or had any of the following conditions:

	Yes	No
a. Been hospitalized or had surgery?	☐	☐
b. Hepatitis, colitis, rectal disease, spleen problems, jaundice or other digestive problems?	☐	☐
c. Gout, arthritis, or lupus?	☐	☐
d. Any indication of, but not limited to the following: ankylosing spondylitis, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc(s), spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, or spondylosis?	☐	☐
e. Obesity, bulimia, anorexia, medically supervised weight control, stomach stapling, or gastric bypass?	☐	☐
f. Tuberculosis, asthma, pleurisy, emphysema, or any disorder of the lungs or respiratory system?	☐	☐
g. Alcohol use, or attended Alcoholics Anonymous?	☐	☐
h. Drug dependency, abuse of, or reaction to drugs?	☐	☐
i. Been a user of any drug not prescribed, such as opiates, stimulants, depressants and/or hallucinogens?	☐	☐

LIFE HEALTH HISTORY

11. Has any proposed insured been diagnosed, treated, or had any of the following conditions within their lifetime:

	Yes	No
a. Any birth defect, developmental or learning disability, physical, neurological or mental impairment(s)?	☐	☐
b. Kidney disorder, liver problems, cirrhosis or pancreas problems?	☐	☐
c. Cancer or tumors?	☐	☐
d. Diabetes?	☐	☐
e. Multiple sclerosis, muscular dystrophy, cerebral palsy, or any other neurological disorder?	☐	☐
f. Any blood disorder, tested positive for Human Immunodeficiency Virus (HIV) or been treated for or been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any disease or disorder of the immune system?	☐	☐
g. Any heart condition or problem, heart murmur, heart attack, rapid, slow, or irregular heartbeat, blood clot, stroke, or other circulatory problem?	☐	☐

MISC. HEALTH INFORMATION

	Yes	No
12. In the last 5 years, has anyone been unable to work or been unable to perform routine daily functions for more than 2 weeks (other than pregnancy)?	☐	☐
13. In the last 10 years, has anyone had any conditions, symptoms, or problems not otherwise mentioned in connection with answering the questions above?	☐	☐
14. To the best of your knowledge, has anyone been denied or turned down for other health or life insurance or been issued a modified or rated policy?	☐	☐
15. Are you or any dependent(s) disabled? If yes, indicate name(s):	☐	☐

____

____

16. List below the height, current weight, and last year's weight for the employee and spouse.

EMPLOYEE:
Height: _____ft. _____in.
Current Weight: __________lbs.
Last Year's Weight: __________lbs.

SPOUSE:
Height: _____ft. _____in.
Current Weight: __________lbs.
Last Year's Weight: __________lbs.

G. - ADDITIONAL INFORMATION

For every yes answer in the Health History section, complete the following information:

Question #	First Name of Individual Receiving Treatment	Diagnosis of illness, injury, treatment, testing, or medical attention	Start Date	End Date	Remaining Symptoms or Problems	Name & Phone # of Physician or Hospital	
			mo/day/yr	mo/day/yr		Name	Phone #

H. - PRESCRIPTION INFORMATION

First Name of Individual	Name of Medication	Dosage	Start Date	End Date	Reason for Medication	Name & Phone # of Prescribing Physician	
			mo/day/yr	mo/day/yr		Name	Phone #

I. - AGREEMENT AND AUTHORIZATION

I hereby apply for membership with Altius Health Plans (Altius) for the persons listed on this enrollment form (collectively referred to as Enrolled Family). I understand that my enrollment and benefits are in accordance with and described in the applicable Evidence of Coverage and Group Service Agreement. I authorize 1) all health providers and insurers to furnish Altius, and 2) all health providers and Altius to furnish all insurers and health providers records concerning me or any member of my Enrolled Family for whom information is requested for any purpose required for the coverage of benefits including, but not limited to, the coordination of payments with other insurers or in connection with the provision of medical care. I understand that I or my authorized representative may receive a copy of this form containing this authorization for disclosure of information. A photographic copy of this authorization shall be valid as the original. I authorize my employer to deduct from my wages the amount required (if any) to cover my contribution for coverage. I certify that all the above information is correct. For claim adjudication purposes, this authorization is valid for the duration of my coverage for health benefits through Altius. For purposes of collecting information for an insurance policy application, policy reinstatement, or a request for change in policy benefits, this authorization shall remain valid for 30 months from the date the authorization is signed.

I understand that if I and/or my dependent(s), if any, waive coverage, I may not again be eligible for coverage until the next open enrollment period, which is established by my employer and Altius. If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my dependents in this plan if I or my dependents lose eligibility for that other coverage (or if the employer stops contributing towards my or my dependents' other coverage). However, I must request enrollment within 30 days after my or my dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents. However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Requests for special enrollment or more information may be directed to Altius Health Plans, Customer Service Department, 801-323-6200 or 800-377-4161.

By signing this form, I agree on behalf of myself and my Enrolled Family that Altius may use or disclose to third parties the information contained on this enrollment form and individually identifiable health information relating to my Enrolled Family for purposes of administering my health insurance benefits including treatment, payment, or health care operations, as those terms are explained in detail in the Altius Notice of Privacy Practices and to the extent permitted by law. My Enrolled Family's consent includes agreement for the use or disclosure of health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness, including substance abuse, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV). By signing this form, I also agree on behalf of myself and my Enrolled Family, to the extent permitted by law, health care providers, insurers, claims administrators, employers, and others may disclose my Enrolled Family's personal information including individually identifiable health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness including substance abuse, AIDS, ARC, or HIV to Altius for administration of health insurance benefits including treatment, payment, or health care operations purposes and other purposes permitted by law.

I have read and agree to the statements above.

Signature: ____ Date: ______________________

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