Small Group Employee Application

COMMON GROUND
HEALTHCARE COOPERATIVE

IMPORTANT - PLEASE READ CAREFULLY

Information provided on this application is solely for the purpose of administering the CGHC plan(s) offered through your employer.

To enroll in Common Ground Healthcare Cooperative Plan:

- Answer every question, providing complete information about yourself and family members you want to cover.
- If information is missing or incomplete, your enrollment may be delayed and/or your coverage may be limited.
- Please provide Social Security numbers to match your enrollment information to your assigned Member ID number for administrative purposes.

To submit your application:

- Please review all information for completeness and accuracy.
- Be sure to sign and date the application.
- Submit the application to your employer or as instructed by your employer.

Section I-Enrollment Information

• Event Status: ☐ New Group ☐ New Hire ☐ Other: _____ ☐ Special Enrollment Period (Describe):

• Employee Status: ☐ Active Employee ☐ New Hire ☐ Waiver ☐ Cobra/Continuation

Name of Employer	**Group Number**	**Effective Date**

Section II-Employee Information

First Name	**M.I.**	**Last Name**	**HRS Worked per wk.**	**Hire Date**

Home Address- street address

City	**State**	**ZIP Code**	**County**	**Email Address**

Primary phone (include area code)	**Secondary phone** (include area code)	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Windowed ☐ Domestic Partner

Section III- Plan Selection

Please indicate the CGHC Plan that you are enrolling in: _____

I am applying for coverage for: (check all that apply)

- ☐ Myself
- ☐ My spouse
- ☐ My dependent child(ren)
- ☐ Domestic partner (if coverage is offered by your employer.) Must complete Domestic Partnership attestation.

Section IV- Other Insurance Information

Will you or any family members covered by this policy have other health insurance coverage when this policy becomes effective?	☐ **YES** ☐ **NO**

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Section V – Applicant Information- List all family membrs to be covered.

EMPLOYEE:

EMPLOYEE	Social Security Number	Are you disabled? (Y/N)	Date of Birth (MM/DD/YYYY)	Relationship SELF	Sex

DEPENDENTS: (Indicate last name ONLY if different than employee)

Name (First,MI,Last)	Social Security Number	Are you disabled? (Y/N)	Date of Birth (MM/DD/YYYY)	Relationship	Sex

Section VI– Employee's Authorization and Representation

Read this section carefully, sign and date the application.

I hereby apply for coverage on the basis of the statements and answers to the questions herein. I hereby represent all answers to be true to the best of my knowledge and to accurately represent the health of those persons applying for coverage and waiving coverage. I understand that these statements, answers, and subsequent information I provide are the basis for my coverage. **I understand that if my application for new or additional coverage is accepted, that applicable coverage will not be effective until after I am notified of the Effective Date**.

I hereby authorize Common Ground Healthcare Cooperative(CGHC) to obtain from providers of services and hospitals, including those providers with whom CGHC contracts for service, the medical records, including those which relate to mental health and chemical dependency treatment, relating to me and my family members to the extent that those records are necessary for the administration of the CGHC contract, including for purposes of claims payment, case management, fraud investigation and quality of care review. A photocopy of this authorization shall be as valid as the original and remains in effect as long as continually insured by CGHC or until revoked.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION TO COMMON GROUND HEALTHCARE COOPERATIVE IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIMS OR CANCELLATION OR RESCISSION OF COVERAGE.

Employee Signature: **Date of Signature:**

Complete the waiver on page 3 if waiving/declining group coverage.

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Section VII – Waiver of Coverage

I am declining group health coverage for: ☐ Myself ☐ Myself and all eligible dependents ☐ My eligible dependents listed below

Complete the following for all dependents waiving coverage:

Name (First, M.I., Last)	Relationship to Employee	Date of Birth	Sex

Please check the reason(s) why you and/or your dependents are waiving coverage.

- ☐ Persons listed above have other group coverage. **Please complete section below*.**
- ☐ Persons listed above are covered by Medicare or Medicaid (Badger Care). **Please complete section below*.**
- ☐ Persons listed above have other individual coverage. **Please complete section below*.**
- ☐ I am, and my dependents are, in good health.

***Complete this section if you or your dependents have other insurance coverage.**

Name of Carrier	Phone Number of Carrier	Policy Number	Name of Policyholder

I also understand that if I apply for coverage in the future, I and/or my eligible dependents will be considered a Late Enrollee(s) and must wait for the group's renewal/anniversary date to enroll provided I and/or my eligible dependents are still eligible for coverage and are not entitled to a special enrollment period as described below.

Further, I certify that I and/or my eligible dependents have not been influenced in any way to waive coverage through CGHC by my employer, agent, or Common Ground Healthcare Cooperative.

Employee Signature: **Date of Signature:**

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself and/or your dependents (including spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and/or your dependents in this plan, provided that you request enrollment within 30 days after the qualifying event.

In addition, if you have a new dependent as a result of marriage or birth you may be able to enroll yourself and/or your dependents, provided that you request enrollment within 30 days after the marriage or birth. If you have a new dependent as a result of an adoption or placement for adoption, coverage begins from the date of adoption or the date of placement, whichever is earlier. We must receive notification of the adoption within 60 days after the date of adoption or placement.