Small Group Employee Application

COMMON GROUND HEALTHCARE COOPERATIVE

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

Hire Date: ________________.

Average Hours Worked Per Week: ____________.

Coverage Effective Date: ________________.

Section I – Enrollment Information

Event Status: ☐ New Group ☐ New Hire ☐ Special Enrollment Period:

Name of Employer

Section II – Employee Information

First Name	M.I.	Last Name

Home Address

City	State	ZIP Code	County

Phone	Email	Marital Status
		☐Single ☐Married ☐Divorced ☐Widowed ☐Domestic Partner

Employee status, select all that apply:
☐ Hourly ☐ Salaried ☐ Management ☐ Non-Management ☐ Union ☐ Non-Union ☐ Executives
☐ Other: ____________________

Section III – Waiver of Coverage

Complete the following for all waiving coverage:

Name (First, M.I., Last)	Relationship to Employee	Reason for Waiving	Carrier (if other coverage)
		☐ Other Group Coverage ☐ Individual Coverage ☐ Medicare or Medicaid ☐ No Coverage	
		☐ Other Group Coverage ☐ Individual Coverage ☐ Medicare or Medicaid ☐ No Coverage	
		☐ Other Group Coverage ☐ Individual Coverage ☐ Medicare or Medicaid ☐ No Coverage	
		☐ Other Group Coverage ☐ Individual Coverage ☐ Medicare or Medicaid ☐ No Coverage	
		☐ Other Group Coverage ☐ Individual Coverage ☐ Medicare or Medicaid ☐ No Coverage	
		☐ Other Group Coverage ☐ Individual Coverage ☐ Medicare or Medicaid ☐ No Coverage	
		☐ Other Group Coverage ☐ Individual Coverage ☐ Medicare or Medicaid ☐ No Coverage	
		☐ Other Group Coverage ☐ Individual Coverage ☐ Medicare or Medicaid ☐ No Coverage	

I also understand that if I apply for coverage in the future, I and/or my eligible dependents will be considered a Late Enrollee 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 in the Notice of Special Enrollment Rights on Page 2.

Waiving Employee Signature:	Date of Signature:

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Section IV – Application for Coverage

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

- ☐ Myself
- ☐ My spouse
- ☐ My dependent child(ren)
- ☐ Domestic partner (if coverage is offered by your employer)

Please list the full name of the benefit plan you are selecting:
Example: Gold $800 Deductible/20% - Envision Network ____________________________________.

Will any enrolling members have other health insurance coverage when this policy becomes effective? ☐ YES ☐ NO

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

EMPLOYEE:

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

DEPENDENTS:

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

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.

Applying Employee Signature: **Date of Signature:**

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself and/or your dependents because of other qualified 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 the qualifying Special Enrollment Period.