univera HEALTHCARE

**FOR INTERNAL USE ONLY**
HIOS ID# _____
EC _____

# Commercial Group Health Insurance Application/Change Form

**CONFIDENTIAL**

Please print clearly and complete all sections that apply. Signatures are required. Additional instructions included on Page 4.

## Section 1: Employer Group & Benefit Information

**To be completed with your Group Administrator**

Employer Name _____ Association/Chamber Name (if applicable) _____

**Check Desired Action**
☐ Add ☐ Cancel ☐ Change

Group Administrator's Signature (required) _____ Date _____

Employee Number _____ Department Number _____

### Medical Information

Medical Group Number (8 digits) _____

Subgroup _____ Class _____

**Who's covered?**
☐Self Only
☐Self & Child(ren)
☐Self & Spouse/Domestic Partner
☐Family

**Medical Effective Date** _____ / _____ / _____

**Subscriber Status:**
☐Actively Working
☐Retired
☐Disabled
☐Canceled
☐COBRA

### Medical Plan Selection

☐ Please choose plan options from dropdowns

☐

☐

☐

☐

☐

### Dental Information

Dental Group Number _____

Subgroup _____ Class _____

**Who's covered?**
☐Self Only
☐Self & Child(ren)
☐Self & Spouse/Domestic Partner
☐Family

**Dental Effective Date** _____ / _____ / _____

### Dental Plan Selection

☐ Please choose plan options from dropdowns

☐

### Vision Information

Vision Group Number _____

Subgroup _____ Class _____

**Who's covered?**
☐Self Only
☐Self & Child(ren)
☐Self & Spouse/Domestic Partner
☐Family

**Vision Effective Date** _____ / _____ / _____

### Vision Plan Selection

☐ Please choose plan options from dropdowns

☐

## Section 2: Subscriber's Information

**Last Name** _____

**First Name** _____

**Middle Initial** _____ **Title (e.g., Jr, Sr, III, etc.)** _____

**Street Address** _____

**City** _____ **State** _____

**Zip Code** _____ **Phone** _____

**Birthdate**: _____ / _____ / _____

**Gender**:
☐Female
☐Male
☐Gender X

**Gender identity (optional)**:
☐Transgender Male
☐Transgender Female
☐Prefer to self-describe: _____
☐Prefer not to say
☐Non-binary

**Social Security Number**** _____

**Date of Hire/Rehire**: _____ / _____ / _____

**Retirement Date**: _____ / _____ / _____

☐Age 65+ ☐Disability
☐End Stage Renal *

**Subscriber's Medicare Number** (if applicable) _____

**Medicare Part A** Effective Date _____ / _____ / _____

**Medicare Part B** Effective Date _____ / _____ / _____

Primary Care Physician's Last Name _____ First Name _____ Zip Code _____

Ob/Gyn's Last Name _____ First Name _____ Zip Code _____

Subscriber's Last Name: _____

## Section 3: Reason for enrollment or change

**To be completed by the Group Administrator** **Not required for cancelations**

**Enrollment Opportunity**: ☐New Hire ☐Rehire ☐Open Enrollment ☐Medicare eligible

**Special Enrollment Opportunity:** ☐Newly Eligible Dependent: ☐Newborn ☐Marriage ☐Other _____

☐Change in employment status ☐A move in or out of the service area

☐Involuntary loss of coverage ☐Former dependent regains eligibility

**Date of Event** ___ . ___ . _____

**COBRA Election - Please indicate the reason for COBRA if applicable:**

☐Left Employment/Retired ☐Divorce/Legal Separation ☐Loss of Student Status ☐Death of Spouse

☐Disability ☐Dependent Reached Max Age ☐ Other: _____

**Demographic Change:** ☐Address ☐Birthdate ☐Subscriber Name ☐Dependent Name ☐Phone Number

## Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?

**Subscriber**

| Cancel Code: | Medical Cancel Date: | Dental Cancel Date: | Vision Cancel Date: |
|---|---|---|---|
| | | | |

**Cancel Codes:**

SB02-Left Employment SB58-Change in Employee Eligibility Status SB08-Subgroup Transfer*

SB06-Employee No Longer Wants Coverage* (subscriber request) SB57- Layoff Without Benefits

SB07-Deceased SB09-Enrolled in Error* SB44-Medicare Eligible (Moved to Medicare plan with same employer)

* = Not eligible for COBRA

**Dependent(s)**

| Name: | Cancel Code: | Medical Cancel Date: | Dental Cancel Date: | Vision Cancel Date: |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

* = Not eligible for COBRA

**Cancel Codes:**

M002-Deceased* M005-Divorced M010-Overage Dependent M014-YA No Longer Qualifies* M013-Ineligible Dependent

M003-Subscriber No Longer Wants to Cover Dependent* M007-Dependent No Longer Wants Coverage* M009-Marriage

M011-No Longer a Student M004-Enrolled in Error* M008-Moved Out of Area* M040-Medicare Same Group*

## Section 5: Information about who you would like coverage for (dependent information)

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Adult Disabled Dependent (Separate application form required)

☐Other_____

_____ _____ _____ _____

**Last Name** (if different) Title **First Name** MI **Social Security Number** **

**Gender**: ☐Female ☐Male ☐Gender X **Birthdate** _____ , _____ , _____

**Gender identity (optional):** ☐Transgender Male ☐Transgender Female ☐Non-binary ☐Prefer not to say ☐Prefer to self-describe: _____

Is dependent a full-time student over age 19? ☐Yes ☐No Married? ☐No ☐Yes ___ , ___ , ____ Expected Graduation Date: _____ , _____ , _____

If yes, please provide name of college/university _____ Will dependent further education after graduation? ☐Yes ☐No

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal *

_____ Part A Effective Date: ___ . ___ . ____ Part B Effective Date: ___ . ___ . ____

Medicare Number (if applicable)

_____ _____ _____ _____ _____ _____

Primary Care Physician's Last Name First Name Zip Code Ob/Gyn's Last Name First Name Zip Code

**↓ Additional Dependent(s) ↓**

☐Dependent Child ☐Adult Disabled Dependent (Separate application form required) ☐Other_____

_____ _____ _____ _____

**Last Name** (if different) Title **First Name** MI **Social Security Number** **

**Gender**: ☐Female ☐Male ☐Gender X **Birthdate** _____ , _____ , _____

**Gender identity (optional):** ☐Transgender Male ☐Transgender Female ☐Non-binary ☐Prefer not to say ☐Prefer to self-describe: _____

Is dependent a full-time student over age 19? ☐Yes ☐No Married? ☐No ☐Yes ___ , ___ , ____ Expected Graduation Date: _____ , _____ , _____

If yes, please provide name of college/university _____ Will dependent further education after graduation? ☐Yes ☐No

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal *

_____ Part A Effective Date: ___ , ___ , ____ Part B Effective Date: ___ , ___ , ____

Medicare Number (if applicable)

_____ _____ _____ _____ _____ _____

Primary Care Physician's Last Name First Name Zip Code Ob/Gyn's Last Name First Name Zip Code

☐Dependent Child ☐Adult Disabled Dependent (Separate application form required) ☐Other_____

**Last Name** (if different) Title **First Name** MI **Social Security Number** **

**Gender**: ☐Female ☐Male ☐Gender X **Birthdate** _____ , _____ , _____
**Gender identity (optional):** ☐Transgender Male ☐Transgender Female ☐Non-binary ☐Prefer not to say ☐Prefer to self-describe: _____

Is dependent a full-time student over age 19? ☐Yes ☐No Married? ☐No ☐Yes ___ , ___ , ____ Expected Graduation Date: _____ , _____ , _____
If yes, please provide name of college/university _____ Will dependent further education after graduation? ☐Yes ☐No

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal *

_____ Part A Effective Date: ___ , ___ , ____ Part B Effective Date: ___ , ___ , ____
Medicare Number (if applicable)

Primary Care Physician's Last Name First Name Zip Code Ob/Gyn's Last Name First Name Zip Code

**Note: Use an additional application or addendum if more than three dependents need coverage**

## Section 6: Other coverage information (Required) - You may be contacted for additional information

Have you or any member of your family been enrolled in other medical or dental coverage? ☐Yes ☐No
If yes, what type of coverage? ☐Medical ☐Dental
What is the effective date of the other coverage? ☐Medical: ____ , ____ , _____ ☐Dental: ____ , ____ , _____
What is the name of the other carrier? _____
Are you keeping the coverage? ☐Yes ☐No
If no, when will the coverage end? ☐Medical: ____ , ____ , _____ ☐Dental: ____ , ____ , _____
Policyholder's name _____ ID#(s) _____
Who did the insurance cover? ☐Self Only ☐Self & Spouse/Domestic Partner ☐Self & Child(ren) ☐Family

## Section 7: Release - You must sign and date this form to be eligible for health insurance

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who accepts coverage under the terms of the contract applicable to my coverage (who may include, for example my spouse and my eligible family dependents).
I hereby accept responsibility for payment of any portion of the premium.
I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.
Pediatric dental is an essential health benefit mandated by the ACA. If your employer group does not provide pediatric dental coverage through this Univera Healthcare plan, you agree to enroll in the dental plan offered to you by your employer.

**EXCLUSIVE PROVIDER ORGANIZATION (EPO)** I understand that if I elect Exclusive Provider Organization (EPO) coverage, except in an emergency, all care must be provided by medical providers who participate with the EPO and I will not receive benefits for care that I receive from providers who do not participate with the EPO. **HEALTH MAINTENANCE ORGANIZATION (HMO)** I understand that I have elected a Health Maintenance Organization (HMO) plan and that I am required to choose a Primary Care Provider (PCP) who will provide my primary care, oversee my other health care services, and, when required, obtain prior approval for certain services such as Inpatient Facility care. **PREFERRED PROVIDER ORGANIZATION (PPO)** I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and out-of-network benefit that provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan. **POINT OF SERVICE (POS)** I understand that the Point of Service (POS) plan provides services on two benefit levels: in-network or out-of-network benefits. I understand that the in-network benefit provides the highest level of coverage under the plan and that I must choose a Primary Care Provider (PCP) to provide my primary care, oversee my other health care services, and, when required, obtain prior approval for certain services such as Inpatient Facility care.

I have thoroughly read, understand and agree to comply with the terms of the release in this section.

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for 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 shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.**

**Subscriber Signature** _____ **Date** _____

Please return to P.O. Box 211256 Eagan, MN 55121-2656
If you have questions, please contact your Group Administrator. Or, visit us at: UniveraHealthcare.com

## Instructions for completing the Group Health Insurance Application/Change Form

**Section 1: Employer Group & Benefit Information**
This section should be completed with your Group Administrator. Group Administrator's signature is required. Medical, dental and/or vision group numbers and information must be populated. Select who you need coverage for on the medical, dental and/or vision plan(s). Next, select the medical, dental and/or vision plan(s) you are enrolling in. All products may not be applicable to your employer group. Please check with your Group Administrator. Indicate the subscriber's status.

**Section 2: Subscriber's Information**
This section should be completed by the Subscriber. **We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act. * There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.

**Gender and gender identity**: Univera Healthcare does not discriminate on the basis of gender identity, gender expression or behavior. In order to ensure that you are receiving access to high quality, affordable health care based on your individual needs, we ask that you consider completing this **optional gender identity section** of the application. Univera Healthcare will not limit coverage or impose any additional cost-sharing for any otherwise-covered services that are ordinarily available to individuals of one sex, to a transgender individual, based on the fact that an individual's sex assigned at birth, gender identity, gender expression or behavior or gender otherwise recorded is different from the gender for which health care services are ordinarily available.

**Section 3: Reason for enrollment or change**
Select the box(es) that describe(s) the reason for this enrollment or change regarding health insurance coverage and include the date of the event. An event is a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request must be received within 30 days of the event date. Please see your Group Administrator for events that fall outside the 30-day period. You may be required to provide documentation of certain events.

**Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?**
If you are canceling coverage, complete the appropriate section for who you are canceling. List the cancel code and enter the date(s) the coverage is to be canceled. List each applicable dependent to be canceled.

**Section 5: Information about who you would like coverage for (dependent information)**
Please include information about all the people who you would like coverage for.
Use an additional application or addendum if more than three dependents need coverage.
If your dependents are Medicare eligible, complete the questions regarding Medicare coverage.
Qualified guidelines for coverage include:

- A legal spouse/domestic partner (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the county clerk)
- Must be under the eligible child age for your employer group including natural, adopted or stepchild(ren)
- Child(ren) Only coverage is available for children up to age 26 or 29 depending on the employer group coverage.
- There are additional eligibility requirements for dependents pending adoption, for which you are the legal guardian, and/or a disabled dependent who is over the maximum dependent age. Please contact your Group Administrator for the appropriate form.

**We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.
* There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.
A separate Adult Disabled Dependent application form is required for applicable dependents. Please contact your Group Administrator for the appropriate forms.

**Section 6: Other coverage information (Required)**
Please include accurate information in this section. This could affect the processing of your application and/or claims.

**Section 7: Release**
Subscriber signature and date are required in this section. The subscriber must sign the application prior to or within 30 days of the effective date or qualifying event date.