

Employee Name:	Employer Name:
	Policy Number / Group ID: (Use to add an Employee to an existing plan)

WYOMING LAWYERS HEALTH BENEFIT PLAN

EMPLOYEE APPLICATION FOR GROUP HEALTH



CONTACT:

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Employee Name: _____

Statement of HIPAA Portability Rights

Pre-existing condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual’s enrollment. These restrictions are known as “pre-existing condition exclusions.” A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a specified period of time before your “enrollment date.” Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period. In addition, a pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (in some cases, 18 months if you are a late enrollee). Finally, a pre-existing condition exclusion cannot apply to pregnancy or genetic information and cannot apply to a child who is enrolled in health coverage within 31 days after birth, adoption, or placement for adoption.

If a plan imposes a pre-existing condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Creditable coverage includes: a group health plan, COBRA continuation coverage, health insurance coverage, Medicare, Medicaid, coverage under Title 10, Chapter 55, United States Code (Tricare), a health plan offered under Title 5, chapter 89 of the United States Code (Federal Government Plan), State Children’s Health Insurance Program (SCHIP), coverage through a high-risk pool in any state, the Peace Corps, a medical program of Indian health service or tribal organization, foreign nationalized healthcare coverage, and a public health plan. If you do not receive a certificate for past coverage, talk to your previous plan administrator.

You can add up any creditable coverage you have. However, if at any time you went for 63 days from the date the Certificate of Credible Coverage was issued or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to enroll in another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment according to the Special Enrollment provisions of your plan (usually within 30 or 60 days). (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse’s plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an “eligible individual,” you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a pre-existing condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan;
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

I ACKNOWLEDGE that I have read the statement of HIPAA Portability Rights. _____

I have prior creditable coverage Yes No. If yes, I understand I must submit a certificate of creditable coverage to Allegiance Benefit Plan Management, Inc.

Employee Name:

SECTION 1: EMPLOYEE

Employer Name:

First Name:	Middle Initial:	Last Name:
Date of Birth (mo/day/year): / /	Social Security Number:	Gender:
Mailing Address:		
City:	State:	Zip:
Daytime Phone Number: ()	Evening Phone Number: ()	

SECTION 2: SPOUSE/DEPENDENTS

FIRST INITIAL LAST	SOCIAL SECURITY NUMBER	BIRTH DATE	SEX	RELATIONSHIP	RESIDES WITH EMPLOYEE YES / NO	TO BE COVERED YES/ NO
LEGAL SPOUSE						
Marriage Date ____ - ____ - ____						
List Child						
List Child						
List Child						
List Child						
List Child						

SECTION 3: OTHER HEALTH COVERAGE INFORMATION

Other Health Coverage? Yes (complete below) No
 (* Please do not include coverage this plan is replacing unless you will continue to be covered under your existing plan.)

Please check the coverage currently being provided elsewhere:
 ____ Medical ____ Dental ____ Vision ____ Pharmacy

List all family members, including yourself, who are covered by other health coverage at the present time:

SELF: <input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No	Child/Children <input type="checkbox"/> Yes <input type="checkbox"/> No
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If you checked **YES** please list dependents below:

SPOUSE:	Coverage ends:	CHILD:	Coverage ends:
CHILD:	Coverage ends:	CHILD:	Coverage ends:
CHILD:	Coverage ends:	CHILD:	Coverage ends:

Provide name, phone number and address of your other insurance company or benefits plan:	Policy/Certificate Number:	Effective Date:
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Employee Name:

Policyholder's name:		Social Security Number:		Date of Birth:	
If you and/or your dependents are enrolled in Medicare Part A, Part B, &/or Part D or Medicaid, please complete the following:					
Enrollee's name(s):	Medicare/Medicaid ID#:	Medicare Part A Effective Date:	Medicare Part B Effective Date:	Medicare Part D Effective Date:	Medicaid Effective Date:
Have you and/or your dependents been covered by a plan administrated by Allegiance Benefit Plan Management, Inc. in the past two years? <input type="checkbox"/> Yes (complete below) <input type="checkbox"/> No					
Group Name:				Group Number:	

SECTION 4: MEDICAL HISTORY
(Use additional paper, if necessary)

I. Please list current height and weight for all persons to be covered.

Name	Current Height	Current Weight	Name	Current Height	Current Weight

II. Within the last three years, have medications (except antibiotics) been prescribed for any person to be covered?

Name	Name of medication	Condition for which medication was prescribed	Dates		Provider Name (First and Last)
			From	To	

III. Does any family member have reason to believe that she or he is an expectant parent (by positive result of laboratory results, provider test, home pregnancy test, etc.)? Yes No If yes, due date: _____
 Twins or Other Multiple(s) Expected? Yes No C-Section Expected? Yes No
 Complications? Yes No If yes, describe:

IV. Has any person to be covered EVER had or been diagnosed with or treated for any of the following? Yes No
 If yes, please explain below.

1. <input type="checkbox"/> AIDS	2. <input type="checkbox"/> Alcohol Use	3. <input type="checkbox"/> Blood or Coagulation Disorder	4. <input type="checkbox"/> Cancer		
5. <input type="checkbox"/> Chemotherapy/ Radiation	6. <input type="checkbox"/> Colon or Intestinal Disorder	7. <input type="checkbox"/> Congenital Defect	8. <input type="checkbox"/> Diabetes		
9. <input type="checkbox"/> Drug Use	10. <input type="checkbox"/> Heart Problems	11. <input type="checkbox"/> HIV Positive	12. <input type="checkbox"/> Liver Disorder		
13. <input type="checkbox"/> Mental Disease	14. <input type="checkbox"/> Nervous System Disorder	15. <input type="checkbox"/> Rheumatic Fever	16. <input type="checkbox"/> Seizure Disorder/ Epilepsy		
17. <input type="checkbox"/> Sleep Apnea	18. <input type="checkbox"/> Stroke or Circulatory Problems	19. <input type="checkbox"/> Tumor	20. <input type="checkbox"/> Weight Loss Procedure (gastric bypass)		
Condition Number (1-20)	Hospitalized? Yes or No	Name	Diagnosis	Dates (From/To)	Complete Provider/ Facility Name & Address

Employee Name: _____

V. Has any person to be covered EVER had or been diagnosed with, treated for, any complaint, illness, disorder, or disease related to any of the following in the past five years? Yes No
If yes, please explain below.

22. <input type="checkbox"/> Attention Deficit Hyperactivity Disorder (ADHD)	23. <input type="checkbox"/> Allergy	24. <input type="checkbox"/> Anxiety/ Depression	25. <input type="checkbox"/> Arthritis
26. <input type="checkbox"/> Asthma	27. <input type="checkbox"/> Back/Neck	28. <input type="checkbox"/> Breasts	29. <input type="checkbox"/> Counseling
30. <input type="checkbox"/> Ear (e.g., infection, hearing impairment)	31. <input type="checkbox"/> Eating	32. <input type="checkbox"/> Eyes (e.g., crossed eyes, detached retina, cataract, glaucoma)	33. <input type="checkbox"/> Fractures
34. <input type="checkbox"/> Gastric Reflux	35. <input type="checkbox"/> Headaches/ Migraines	36. <input type="checkbox"/> Hernia	37. <input type="checkbox"/> High Blood Pressure (complete section VI)
38. <input type="checkbox"/> Infertility	39. <input type="checkbox"/> Joints	40. <input type="checkbox"/> Kidneys	41. <input type="checkbox"/> Lungs
42. <input type="checkbox"/> Nasal/Sinus	43. <input type="checkbox"/> Osteoporosis	44. <input type="checkbox"/> Prostate	45. <input type="checkbox"/> Reproductive Organs
46. <input type="checkbox"/> Suicide Attempt	47. <input type="checkbox"/> Systemic or Discoid Lupus / Connective Tissue Disorder	48. <input type="checkbox"/> Thyroid	49. <input type="checkbox"/> Ulcer
50. <input type="checkbox"/> Urinary Tract	51. <input type="checkbox"/> Other		

Condition Number (22-51)	Hospitalized? Yes or No	Name	Diagnosis	Dates (From/To)	Complete Provider/ Facility Name & Address

Use additional paper if necessary.

VI. Blood Pressure readings must be provided if answered "Yes" to #37 above. (Please give the three most recent readings, at least one month apart.) Use additional paper, if necessary.

Name	Date Taken	Blood Pressure	Date Taken	Blood Pressure	Date Taken	Blood Pressure

VII. Has any person to be covered received, or been recommended to receive, any medical treatment that has not been listed above? Yes No

If yes, please indicate whether the treatment has been received or recommended, and provide date(s), name(s) of person, and detailed explanation(s).

VIII. Has anyone named in this application used tobacco products during the past 12 months? Yes No
 If "Yes," please complete the following:

Name	Duration?	Frequency?	Cigarettes	Chewing tobacco	Pipe/cigars
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Employee Name:

IX. Has any person to be covered been fitted with any implants or orthopedic device or does any person regularly use durable medical equipment (e.g., crutches, Oxygen, CPAP, wheelchair)? Yes No

If yes, please provide date(s), name(s) of person(s), and detailed explanation(s) Also, note whether this is temporary or permanent.

SECTION 5: CONDITIONS OF ENROLLMENT

I/We UNDERSTAND that providing false, incomplete, inaccurate or incorrect information to any of the questions on the Enrollment Form may be considered insurance fraud and may result in denial or cancellation of coverage from its beginning.

I HEREBY AUTHORIZE my employer to make any required payroll deductions for this coverage. I certify that the information provided is true and correct.

This is an application only. No right is given to me or any person listed on this application until the Trust accepts me/us and premiums are paid.

I/We personally completed the Medical History section of this form, providing all requested information.

All statements made are true and complete for me and for each person applying for coverage.

Each person applying for coverage is in good health, except for those conditions listed.

I/We understand that waiting periods may apply for pre-existing conditions and/or dental coverage.

Information regarding your insurability will be treated as confidential. The Trust or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is P O Box 105, Essex Station, Boston, MA 02112, telephone number 617-426-3660.

The Trust or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted."

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to the Trust, Allegiance Benefit Plan Management, Inc. or its reinsurers, any such information. A photographic copy of this authorization shall be as valid as the original.

SECTION 6: SIGNATURE(S)

I/We understand and agree that the coverage I/We am/are applying for is subject to the group eligibility and enrollment requirements. I/We have read the Conditions of Enrollment. I/We understand and agree to them.

Must also have signature(s) of spouse and/or all dependent(s) 18 and over if applying

Employee Signature:	Date:
Spouse Signature:	Date:
Dependent Signature:	Date:
Dependent Signature:	Date:
Dependent Signature:	Date:

Employee Name:

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Use if extra room was needed above