



GROUP MARKET - SMALL (2-50) ENROLLMENT APPLICATION

P.O. Box 7777, Lancaster, PA 17604-7777
Toll free: 800-796-7460 Fax: 717-581-1319

You, the employee, must complete the application in your own handwriting. Please print clearly using ink. You are solely responsible for its accuracy and completeness. All questions must be answered in full or the application may be returned to you, which may delay the effective date of your coverage.

Employee Information (Must be completed by employee) Employee Enrollment COBRA Enrollment Plan Selection: _____

Last name		First name		MI	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Home address (P.O. Box not acceptable unless rural P.O. Box)				Home phone		Work phone		
City		State	ZIP		Social Security Number			
Primary language <input type="checkbox"/> English <input type="checkbox"/> Spanish		Email address		Date of birth		Height	Weight	Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer name			Occupation/Job title			Hire date		Hours worked per week

Dependent Information (List only those eligible dependents who are enrolling)

If your spouse's last name differs, please provide marriage date: _____. If your dependent child is not legally adopted or is not the birth child of you and/or your spouse, please explain why the child is a dependent. If there is a custodial parent responsible for the care of anyone listed, please attach a copy of a power of attorney or other court-initiated document.

Sex (M/F)	Last name	First name	MI	Social Security Number	Height	Weight	Student/Disabled	Birthdate MM/DD/YY	Smoker (Y/N)
	Spouse						Y N		Y N
	Dependent						Y N		Y N
	Dependent						Y N		Y N
	Dependent						Y N		Y N
	Dependent						Y N		Y N

Other Medical Coverage (All questions must be answered.)

- A. Do any persons on this application intend to continue other group coverage if this application is accepted? Yes No
If yes, name: _____ Insurance company: _____
- B. Does any person applying for coverage have health insurance coverage? Yes No If yes, name: _____
Insurance company: _____ Type of coverage: Group Individual Other
- C. Is any person applying for coverage eligible for Medicare? Yes No If yes, name: _____

Health History - Has any person listed on this application, consulted for, sought treatment, had treatment recommended, received treatment, been surgically treated or been hospitalized for any of the following conditions in the last five years:

(Please answer Yes or No. Incomplete applications will be returned to you for completion which may delay the effective date of your coverage.)

	Yes	No		Yes	No
1. Heart attack, heart murmur, stroke, chest pain, high blood pressure, anemia, varicose veins, or any other disorder of the heart, blood, blood vessels, hyperlipemia or arteriosclerosis, high cholesterol or diabetes? (Provide last three blood pressure readings)	<input type="checkbox"/>	<input type="checkbox"/>	8. Any serious bodily injury, fracture, concussion, burn and/or congenital problems?	<input type="checkbox"/>	<input type="checkbox"/>
2. Ulcer, colitis, gall stone, hernia or any other disorders of the stomach, intestines, rectum, gall bladder or liver?	<input type="checkbox"/>	<input type="checkbox"/>	9. Has any person listed on this application ever been diagnosed as having AIDS or an AIDS-related condition or ever had a positive test result on an HIV test?	<input type="checkbox"/>	<input type="checkbox"/>
3. Arthritis, rheumatic fever, back trouble, or any other disorder of the joints, muscles or bones?	<input type="checkbox"/>	<input type="checkbox"/>	10. Within the last five years, had an X-ray, electrocardiogram, cardiac catheterization or any laboratory test or study?	<input type="checkbox"/>	<input type="checkbox"/>
4. Disorder of the kidneys, blood or albumin, thyroid glands, venereal disease or any related eye disorders, urinary systems, male or female organs or menstrual dysfunction?	<input type="checkbox"/>	<input type="checkbox"/>	11. Within the last 12 months, taken medicine as prescribed by a physician or other health practitioner?	<input type="checkbox"/>	<input type="checkbox"/>
5. Epilepsy, fainting spells, mental or nervous condition, paralysis or any other disorder of the brain or nervous system? If epileptic, date of last seizure: _____	<input type="checkbox"/>	<input type="checkbox"/>	12. Been treated for alcoholism or other drug or substance abuse or been advised to seek treatment for the same?	<input type="checkbox"/>	<input type="checkbox"/>
6. Tuberculosis, asthma, hay fever, adenoidectomy, pleurisy or any other kind of disorder of the lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>	13. Is any female to be covered currently pregnant? If yes, due date (month): _____ <input type="checkbox"/> Single or <input type="checkbox"/> Multiple birth(s) expected?	<input type="checkbox"/>	<input type="checkbox"/>
7. Cancer, cyst or tumor?	<input type="checkbox"/>	<input type="checkbox"/>	14. Is any male listed on this application expecting a child with anyone, even if the mother is not listed on this application?	<input type="checkbox"/>	<input type="checkbox"/>
			15. Any history of pregnancy complication?	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE COMPLETE THE ENTIRE FORM. THIS FORM WILL NOT BE PROCESSED WITHOUT REQUIRED SIGNATURES.

If you answered "Yes" to any of the questions on the previous page, you must complete the following. Please explain and provide FULL DETAILS for each condition(s) checked. (Use additional paper if necessary.)

Question #	Name of patient (as identified on medical record)			Name of hospital, clinic or person providing care	Phone #
Date of onset/treatment (month/year)	Date ended (month/year)	<input type="checkbox"/> Still under treatment?	Address		Suite #
Name of condition(s)/illnesses treated				City, State, ZIP	
Treatment rendered				Medication name (date prescribed/dosage)	
Blood pressure: #1	#2	#3	Blood sugar: #1	#2	#3
Cholesterol: #1			#2 #3		

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Cholesterol: #1			#2 #3		

I understand that my signature and my spouse's signature (if applying for coverage) are mandatory on this release. This application will not be reviewed until these signatures are present. **I AGREE:** All information on this form is correct and true. I understand that it is the basis on which premiums may be determined under the plan. I further authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan. I certify that I am at the employer's place of business in permanent full-time employment. Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy being rescinded. **I ACKNOWLEDGE THAT** I am applying for Preferred Provider Organization (PPO) coverage. I understand I am responsible for a greater portion of the cost of my covered medical costs when I use a non-preferred provider. I understand that under the PPO if I or one of my dependents receives medically necessary covered services from a non-preferred provider, Significa will cover only the lower level benefits set forth in the applicable Certificate of Insurance, and I will be responsible for payment of any amount not covered.

HIPAA Authorization - I/We authorize physicians and other providers to disclose protected health information to Significa Insurance Group, Inc and/or its affiliates. A photocopy of this authorization is acceptable as documentation. This authorization will expire two years from the date of this application. Please make a copy of this signed authorization for your records. I/We may revoke this authorization in writing at any time. (Contact Significa's Customer Service Department for further instructions.) Revocation of this authorization will not affect any action taken before receipt of notice of revocation.

I/We understand the nature of this release. The enrollment process may not continue without the signing of this authorization. I/We also understand that if the person or organization authorized to receive the information described above is not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Conditions of Enrollment - I hereby apply for coverage as checked hereon, made available to me through the group with which I am affiliated. I understand that if this application is accepted, you will provide me with an identification card and certificate of coverage indicating the benefits and conditions of enrollment. I acknowledge that I will be bound by the terms and conditions of the group contract. I am authorized by my dependents listed above to enroll them in a Significa Insurance Group, Inc. health care product. I authorize the Social Security Administration to furnish to Significa Insurance Group, Inc. medical or any other information acquired by it under Title XVIII of the Social Security Act (Medicare) to the extent necessary to process any claim under my agreement. **Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.**

Signature of employee: _____ Date: _____
 Signature of spouse: _____ Date: _____
 Signature of dependent (over 18): _____ Date: _____
 Signature of dependent (over 18): _____ Date: _____

My signature as employee is on behalf of myself and all dependents. If a personal representative is authorizing disclosure of the insured's information on behalf of the insured, a copy of a power of attorney or other court-initiated document will be required, as applicable.

To Decline Coverage To be completed only if you, your spouse or your dependent DO NOT want to enroll.	
A. Coverage declined for:	<input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent(s) <input type="checkbox"/> Spouse and dependent(s)
B. Reason for declining coverage (check one):	<input type="checkbox"/> Covered by spouse's group coverage <input type="checkbox"/> Enrolled in any other insurance carrier plan
<input type="checkbox"/> Other: _____	
Signature (only if declining coverage for employee and/or dependent(s))	Date (MM/DD/YYYY)