ALTIUS
HEALTH PLANS

10421 South Jordan Gateway, Suite 400
South Jordan, Utah 84095

SMALL GROUP (2-50) ENROLLMENT

(Must select PCP)
❑ **Mountain**

(No PCP required)
❑ **Peak Advantage**
❑ **Dental**

(No PCP required)
❑ **Peak Plus**
❑ **Peak Plus Traditional**
❑ **Peak Plus Extended**

For Office Use Only
Group No. _____
Effective Date _____
PEC _____
New Hire Waiting Period _____

IMPORTANT: **INCOMPLETE INFORMATION WILL DELAY ENROLLMENT.** If you have any questions regarding this enrollment application, please call the Customer Service office at **323-6200**, or toll free at **800-377-4161**.

A - EMPLOYER INFORMATION

Employer: _____ Hire Date: _____ Rehire Date: _____

Location: _____ Is this a division? ❑Yes ❑ No

If "Yes," Name of parent company: _____

Coverage	Self	Spouse	Child(ren)	COBRA	State Cont. Coverage	EFFECTIVE DATE
Medical	❑	❑	❑	❑	❑	___ ___ ___
Dental	❑	❑	❑	❑	❑	___ ___ ___

B - EMPLOYEE

- **Mountain:** You must designate each family member's primary care provider (PCP) and provider code. The provider code is the 5 digit number in parentheses next to each PCP in the Altius Provider Listing. All care must be received or arranged through your PCP.
- **All Peak Plans & Dental:** PCP designation is not required. Please refer to the Altius Provider Listing for participating providers.
- **All Plans:** If covering dependent(s) due to court order, attach copy of court documentation. Please include address and telephone number, if different from insured's: _____

Name Last: _____ First: _____ MI: _____ Job Title: _____ Hours per Week: _____

Marital Status: ❑ Divorced ❑ Married ❑ Single ❑ Widowed E-Mail Address: _____

Address: _____ Apt. No.: _____ City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Business Phone: ( ) _____

Spouse's Employer: _____ Spouse's Business Phone: ( ) _____

C - OTHER & PRIOR INSURANCE COVERAGE

Do you or your dependent(s) have other health insurance? ❑ Medical ❑ Rx ❑ Medicare Name of carrier: _____ Phone #: ( ) _____

Policyholder's Name _____ Policy #: _____ Effective date of coverage: _____

Name of covered dependents: _____

If this coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care insurance so that Altius can determine whose coverage is Primary.

If you currently do not have insurance coverage, when was the last date that you were insured?: _____

If you have had continuous health care coverage within the last 63 days, your Pre-Existing Condition (PEC) waiting period limitation may be partially or completely waived. To determine if this applies to you, you must enclose proof of prior coverage, such as a Certificate of Creditable Coverage from you previous carrier.

♦ **Submission of prior coverage information does not automatically waive any Pre-Existing Condition Limitation. However, failure to provide proof of prior coverage will result in an automatic 9-month Pre-Existing Condition Waiting Period.**

E - SUBSCRIBER/DEPENDENTS

MEDICAL **(Mountain Only)** **OTHER COVERAGE**

	Social Security Number	Office Use Only	Name - Last First MI	Date of Birth	Age	M/F	PCP Name	PCP Code	Medical	Rx	Medicare
(1)			Self								
(2)			Spouse								
(3)			Dependent								
(4)			Dependent								
(5)			Dependent								
(6)			Dependent								
(7)			Dependent								
(8)			Dependent								

♦ **Note: Did you fill in Social Security Number(s), physician name(s) and physician code(s)?**

♦ **If any box in OTHER COVERAGE is checked, please fully complete SECTION C.**

Office Use Only
PEC: _____

F - HEALTH HISTORY

Instructions: Answer each question for each individual applying for coverage. Circle the specific item and check the appropriate box for each question. For each "Yes" answer, give complete and specific details in section G.

CURRENT HEALTH

1. Has anyone been under medical care in the last 12 months? ❑ Yes ❑ No

2. Has anyone consulted, been tested, or had treatment by a doctor chiropractor, counselor, therapist, or other health care provider within the past three years? ❑ Yes ❑ No

3. Is any family member currently pregnant or have reason to suspect that they might be pregnant? ❑ Yes ❑ No

4. Are you or your spouse financially responsible for an unborn child, or anticipating adoption within the next 12 months? ❑ Yes ❑ No

5. Does anyone have a problem for which they have not sought medical advice or treatment in the last 12 months? ❑ Yes ❑ No

6. Do you have a spouse or dependent(s) who are not applying for coverage? If yes, complete (a) and (b) below. *(Please refer to Section I)* ❑ Yes ❑ No

a. List the reason(s) why your spouse and/or dependents are not applying for coverage on this policy._____

_____

b. Current health status of those not applying for coverage. _____

_____

7. Has anyone used tobacco in the last 12 months? ❑ Yes ❑ No

8. Has anyone taken any medication, drugs, or shots in the past 12 months? If yes, complete section H. ❑ Yes ❑ No

5-YEAR HEALTH HISTORY

9. Within the past 5 years, has any proposed insured been diagnosed, treated, or had any of the following conditions:

a. Advised to be hospitalized, have tests, have surgery or take medication, but has not done so? ❑ Yes ❑ No

b. Fertility. Is anyone infertile, had miscarriages, or complications of pregnancy? ❑ Yes ❑ No

c. Ulcers, hernia, chronic diarrhea or other digestive problems? ❑ Yes ❑ No

d. Urinary problems or urinary incontinence? ❑ Yes ❑ No

e. Irregular bleeding, abnormal pap smears, pelvic inflammatory disease, endometriosis, prostate or testicular problems, venereal disease or any disorder of the reproductive system? ❑ Yes ❑ No

f. Unconsciousness, epilepsy, seizures, or convulsions? ❑ Yes ❑ No

g. Mental health counseling, psychotherapy, had a mental or nervous disorder, depression, stress or anxiety that interfered with daily life? ❑ Yes ❑ No

h. Cysts, growths (except warts), breast lump(s), breast augmentation or reduction? ❑ Yes ❑ No

i. Skin disorder that required medical attention? ❑ Yes ❑ No

j. Thyroid disorder, disorder of the lymph nodes, or lymph system? ❑ Yes ❑ No

k. Chest pain, high blood pressure, or high cholesterol? ❑ Yes ❑ No

l. Disorder of the eyes, ears, nose, or throat? ❑ Yes ❑ No

m. Back, neck, spinal problems, or a joint disorder that required medical attention and/or interfered with daily functioning? ❑ Yes ❑ No

10-YEAR HEALTH HISTORY

11.Within the past 10 years, has any proposed insured been diagnosed, treated, or had any of the following conditions:

a. Been hospitalized or had surgery? ❑ Yes ❑ No

b. Hepatitis, colitis, rectal disease, spleen problems, jaundice or other digestive problems? ❑ Yes ❑ No

c. Gout, arthritis, or lupus? ❑ Yes ❑ No

d. Any indication of, but not limited to the following: ankylosing spondylitis, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc(s), spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, or spondylosis? ❑ Yes ❑ No

e. Obesity, bulimia, anorexia, medically supervised weight control, stomach stapling, or gastric bypass? ❑ Yes ❑ No

f. Tuberculosis, asthma, pleurisy, emphysema, or any disorder of the lungs or respiratory system? ❑ Yes ❑ No

g. Alcohol use, or attended Alcoholics Anonymous? ❑ Yes ❑ No

h. Drug dependency, abuse of, or reaction to drugs? ❑ Yes ❑ No

i. Been a user of any drug not prescribed, such as opiates, stimulants, depressants and/or hallucinogens? ❑ Yes ❑ No

LIFE HEALTH HISTORY

12. Has any proposed insured been diagnosed, treated, or had any of the following conditions within their lifetime:

a. Any birth defect, developmental or learning disability, physical, neurological or mental impairment(s)? ❑ Yes ❑ No

b. Kidney disorder, liver problems, cirrhosis or pancreas problems? ❑ Yes ❑ No

c. Cancer or tumors? ❑ Yes ❑ No

d. Diabetes? ❑ Yes ❑ No

e. Multiple sclerosis, muscular dystrophy, cerebral palsy, or any other neurological disorder? ❑ Yes ❑ No

f. Any blood disorder, tested positive for Human Immunodeficiency Virus (HIV) or been treated for or been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any disease or disorder of the immune system? ❑ Yes ❑ No

g. Any heart condition or problem, heart murmur, heart attack, rapid, slow, or irregular heartbeat, blood clot, stroke, or other circulatory problem? ❑ Yes ❑ No

MISC. HEALTH INFORMATION

13. In the last 5 years, has anyone been unable to work or been unable to perform routine daily functions for more than 2 weeks (other than pregnancy)? ❑ Yes ❑ No

14. In the last 10 years, has anyone had any conditions, symptoms, or problems not otherwise mentioned in connection with answering the questions above? ❑ Yes ❑ No

15. To the best of your knowledge, has anyone been denied or turned down for other health or life insurance or been issued a modified or rated policy? ❑ Yes ❑ No

16. Are you or any dependent(s) disabled? If yes, indicate name(s):_____ ❑ Yes ❑ No

10. List below the height, current weight, and last year's weight for the employee and spouse.

EMPLOYEE:			**SPOUSE:**		
Height	Current Weight	Last Year's Weight	Height	Current Weight	Last Year's Weight
____ ft. ____ in.	_____	_____	____ ft. ____ in.	_____	_____

G - ADDITIONAL INFORMATION

For every yes answer in the Health History section, complete the following information:

Question #	First Name of Individual Receiving Treatment	Diagnosis of illness, injury, treatment, testing, or medical attention	Start Date mo/day/yr	End Date mo/day/yr	Remaining Symptoms or Problems	Name & Phone # of Physician or Hospital Name	Phone #

H - PRESCRIPTION MEDICATION INFORMATION

First Name of Individual	Name of Medication	Dosage	Start Date mo/day/yr	End Date mo/day/yr	Reason for Medication	Name and Phone # of Prescribing Physician Name	Phone #

I - AUTHORIZATION

I, the Undersigned, hereby:

1. Declare that the foregoing answers, to the best of my knowledge and belief, are true and complete.
2. Authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, or any other organization, institution or person who has any record or knowledge of me or my spouse, or dependents to give such record or information to Altius to the extent necessary to allow responsibility for payment to be determined and payment to be made and/or for utilization review and quality assurance purposes. The authorizations shall be valid for 24 months from the date shown below. However, I may withdraw my consent for release of information at anytime in the future.
3. I further authorize Altius to disclose information from my medical records to my provider of health care to the extent necessary for treatment.
4. I authorize my employer to deduct the required contribution for Altius benefits from my wages. Failure to report any change in eligibility status may result in termination of coverage.
5. I agree to abide by the terms of the Altius Group Service Agreement which contains the benefits, limitations, and exclusions applicable to my health care plan.
6. Upon request, a Customer Service Representative can explain my benefit coverage.
7. I UNDERSTAND that if I and/or my dependent(s), if any, waive coverage, I may not again be eligible for coverage in this program until the next open enrollment period, which is established by my employer and Altius Health Plans. I also understand that unless I am declining enrollment for myself and my dependent(s) (including my spouse) because of other health insurance coverage, I may be subject to a pre-existing condition waiting period of up to 12 months, as specified by the plan. If I am waiving because I have other insurance, I realize that I may in the future be able to enroll myself and any dependent(s) in the plan, provided that I request enrollment within thirty (30) days after my other coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependent(s) provided that I request enrollment within thirty (30) days after such marriage, birth, adoption, or placement for adoption.
7. A reproduced copy of this authorization shall be as valid as the original.
8. I have read and understand the above.

Signature: _____ Date: _____