Lifestyle HEALTH PLANS A World of Wellness

NATIONAL INSURANCE PARTNERS

Employee Health Application Form

Section 1: Employer Information

Employer Name: ____________________ Hire Date: __________

Employer Address: ____________________

City: ____________________ State: __________ Zip: __________

Section 2: Employee Information

Employee Name: ____________________ Date of Birth: __________
Last First M.I. (Month / Day/ Year)

____
Employee Social Security # (Required if Enrolling)

Gender: ☐ Male ☐ Female Tobacco Use: ☐ YES ☐ NO

Address: ____________________ ____________________
Job Title

____
City State Zip

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed

Home Phone: (_______) ____________________ Cell Phone: (_______) ____________________

E-mail Address: ____________________ Hours Worked per Week: __________

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

Section 3: Other Insurance Coverage

1. Are you or any dependent(s) disabled ☐ YES ☐ NO If YES, please indicate name(s): ____________________
2. Do you or your spouse have other health insurance coverage that will continue in addition to this coverage? ☐ YES ☐ NO
   If YES, name of Carrier: ____________________
   Policy Holder's Name: ____________________ Policy #: __________ Effective Date: __________
   Name(s) of Covered Dependents: ____________________

Section 4: Dependent Information (*Please complete for all participating dependents. Attach additional sheets if necessary.)*

First Name Last Name	Relationship (Spouse, Son, Daughter)	Social Security # (Required if Enrolling)	DOB (Month / Day / Year)	Age	M / F	Tobacco Use YES / NO

Section 5: Health Plan Participation

___ I elect to participate
___ I decline participation
If declining, provide reason below:

Coverage Level (*Choose 1*)
___ Employee Only
___ Employee / Spouse
___ Employee / Child(ren)
___ Family

Plan Selected

Options provided upon underwriting approval

Reason for decline:

☐ Spouse's Employer's Plan ☐ Individual Plan ☐ Medicare ☐ Medicaid ☐ COBRA from Prior Employer

☐ VA Eligibility ☐ I (we) have no other coverage at this time ☐ Other: ______________________________

Section 6: Health Information

Please furnish us with the height and weight for you and your spouse:

Self: Height ____ feet _____ inches; Weight ________ lbs **Spouse:** Height ____ feet _____ inches; Weight _______ lbs

Please answer the following health questions regarding any medical conditions or medical treatment for you and your family.

1. Have you or any of your dependent(s) been diagnosed or treated for any of the following conditions in the past five (5) years?

A. Cardiac Disorder ☐ Yes ☐ No
B. Cancer / Tumor (any form) ☐ Yes ☐ No
C. Diabetes ☐ Yes ☐ No
D. Kidney Disorder ☐ Yes ☐ No
E. Respiratory Disorder ☐ Yes ☐ No
F. Liver Disorder ☐ Yes ☐ No
G. High Blood Pressure ☐ Yes ☐ No
H. AIDS / HIV / Immune System Disorder ☐ Yes ☐ No
I. Alcohol / Drug Abuse ☐ Yes ☐ No
J. Mental / Nervous Disorder ☐ Yes ☐ No
K. Neuromuscular Disorder ☐ Yes ☐ No
L. Stomach / Gastrointestinal ☐ Yes ☐ No
M. Arthritis, Back, Bone, Joint Disorder ☐ Yes ☐ No
N. Seizures, Convulsions, Epilepsy ☐ Yes ☐ No
O. Any Other Medical Condition (not listed above) ☐ Yes ☐ No

2. Within the past 5 years, have you or any dependent ever had an application for insurance declined, postponed, rated, or otherwise modified? ……………………………………………………………………................ ☐ Yes ☐ No

3. Have you or any of your dependent(s) had any medical conditions in the past 24 months requiring medical care, prescription management, surgery, or hospitalization? …………………………………………………......... ☐ Yes ☐ No
If Yes, please provide information on who and for what conditions in space provided below.

4. In the past 24 months, have you or any of your dependent(s) had more than $5,000 in medical expenses?........ ☐ Yes ☐ No
If Yes, please provide information on who and for what medical conditions in space provided below.

5. Are you or any of your dependent(s) anticipating hospitalization or surgery, or had surgery or hospitalization recommended that has not been performed? If Yes please provide information below………...... ☐ Yes ☐ No

6. Are you or any dependent(s) currently pregnant or suspect you / they may be pregnant?
If Yes, please provide due date and detail in space provided below. ……………………………………………..…… ☐ Yes ☐ No

If you answer "Yes" to any of the questions above, please provide detail in space provided below.

Question Number	Family Member	Disease / Diagnosis / Treatment	Date of Onset Month / Year	Date Last Seen By Physician	Remaining Symptoms or Problems

(As Necessary, Please Attach Additional Sheets, Signed and Dated by the Employee Subscriber.)

7. **Prescriptions / Medications** - List any medications, prescriptions, or injections taken in the last 12 months.

Family Member Name	Medication / Rx / Injection	Dosage	Medical Condition

(As Necessary, Please Attach Additional Sheets, Signed and Dated by the Employee Subscriber.)

Section 7: Agreements and Authorization

Agreements
The answers and statements on this Employee Health Application are true and complete. I agree that they shall form a part of the contract of insurance under which I am applying for coverage. I understand and agree that the insurance applied for shall not take effect until approved by the insurance carrier at its Home Office. I have read, or have had read to me, the completed application and I realize that any false statements or misrepresentation in the application may result in loss of coverage under the contract.

Fraud Warning
Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

Medical Authorization
I hereby authorize my health plan, healthcare provider, and their applicable business associates to disclose my Protected Health Information ("PHI") to Medova Healthcare Financial Group, LLC and Medova's respective carriers. I authorize Medova Healthcare and Medova's respective carriers to assist me in obtaining health care services, payment information, or account resolution. Medova Healthcare and Medova's respective carriers will not use this information for any purposes other than underwriting, eligibility, precertification and authorization, utilization management, case management, disease management, and patient advocacy services. PHI includes the following: enrollment, claims, payment, or managed-care information.

Unless otherwise revoked in writing, this authorization will commence on the date indicated below and will expire twenty-four months from the date below. I understand that:

- Information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 C.F.R. Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 C.F.R. Part 164), and the Privacy Act of 1974 (5 U.S.C. § 552a).
- I may revoke the authorization at any time by giving written notice of the revocation to Medova Healthcare Financial Group, LLC at 345 N. Riverview, Suite 600, Wichita, KS 67203. Revocation of this authorization will not affect any action that Medova Healthcare, Medova's respective carriers, or any duly authorized representatives, have taken reliance on this authorization before my written notice of revocation was received.
- Medova Healthcare Financial Group LLC provides administrative and informational services for our respective carriers only and does not provide health insurance or medical services, nor does either recommend or endorse any treatment.

In the event that I enroll in a Lifestyle Health Plan, I understand that the aforementioned authorization will remain in force as it relates to the normal functions and duties of Medova Healthcare in conducting their administrative, care coordination, member services, and population health duties and responsibilities. In the event that I enroll in a Lifestyle Health Plan, I hereby agree to abide by the terms and conditions of all benefit plan summary documents, which contain the benefits, limitations, and exclusions applicable to my health and other benefit coverage. Upon request, a customer service representative can explain my benefit coverage options. I have read and understand the above conditions and declarations.

Employee Signature: ______________________________ **Date:** ____________________