DAKOTACARE®

2600 West 49th Street
Sioux Falls, SD 57105-6575
605-334-4000

EMPLOYEE ENROLLMENT APPLICATION

All white areas must be completed to ensure prompt processing.

Applicant Information

Must be completed by Employer: ❑ **New Group**
Employer Name: _____
Client # and Sub Group #: _____ -- _____
Following Employee is:
❑ COBRA - Qualifying Event Date: _____
❑ New Hire by your Firm ❑ Other
❑ Applying during Open Enrollment
❑ Special Enrollment Event: _____
_____
Date Event Occurred: _____
Requested effective date of coverage: _____

Please PRINT Clearly

Your SSN is required solely for the purpose of your positive identification by DAKOTACARE. Your SSN will be protected from disclosure and will not be released or disclosed to any person or party, unless required by law.

Employee Social Security Number

			-			-				

e-mail address: _____

Legal Last Name														Legal First Name										Initial	

○ Single ○ Divorced ○ Married Date of Event _____	Address	City	State	Zip

Home Phone No.	Gender ❑ M ❑ F	Date of Birth	Height	Weight	Annual Salary Not necessary
Date Employed Full-Time ○ Salaried ○ Hourly		Average Hours Worked Per Week		Occupation	

This request for health coverage is for:
○ Self ○ Family ○ Employee/Spouse ○ Employee/Child(ren)

Group Life	LTD	STD
○ Self ○ Family	☐	☐

Family Information – Include for Health & Life

Legal First Name and M.I. (legal last name if different)	Gender	Date of Birth	Height	Weight	Social Security No. (required)	Marital Status	Relationship to Employee
	❑ M ❑ F					○ Single ○ Married	
	❑ M ❑ F					○ Single ○ Married	
	❑ M ❑ F					○ Single ○ Married	
	❑ M ❑ F					○ Single ○ Married	
	❑ M ❑ F					○ Single ○ Married	

(If more space is needed, attach an additional sheet of paper, signed and dated.)
*Eligible dependents may include spouse and natural dependent children, stepchildren, totally disabled children, adopted children, children of whom member has legal guardianship and children who are full-time students.

OTHER INSURANCE WAIVER SECTION

I have been informed that an employer-sponsored health benefit plan is available through my employer to my dependents and me. On behalf of myself and my dependents, I am voluntarily electing not to enroll in the health benefit plan sponsored by my employer. I am not applying for coverage because:

❑ Covered by a spouses group benefit plan
❑ Other Explain: _____

Employee Signature: _____ Date: _____

If you are declining enrollment for yourself and your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that your enrollment request is received within 63 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll along with the newly acquired dependents, provided that your request for enrollment is received within 30 days following the marriage, birth, adoption or placement for adoption.

OTHER COVERAGE INFORMATION

In the last 18 months have you or any family member been covered by any medical insurance including Medicare? ○ No ○ Yes*
*If yes, a copy of the Certificate(s) of Creditable Coverage **MUST** be attached or Pre-existing may apply.

Will this coverage continue **AFTER** the proposed effective date with DAKOTACARE? ❑ No ❑ Yes*
*If yes, a copy of the Other Insurance or Medicare card **MUST** be attached.

Are you currently or have you previously been enrolled by DAKOTACARE?
○ No ○ Yes ID Number: _____

Do you have a court order which states who is responsible to provide medical coverage on the dependents? ❑ No ❑ Yes*
*If yes, a copy of the court order **MUST** be attached.

Life Insurance Beneficiary Section

Primary Beneficiary	Contingent Beneficiary
Name: _____	Name: _____
Address: _____	Address: _____
Relationship: _____	Relationship: _____

FOR DAKOTACARE USE ONLY

Plan:	Effective date:
❑ Self ❑ Family ❑ Employee/Spouse ❑ Employee/Child(ren)	Waiting period: ❑ Applicable ❑ Waiver
	Look back period:

HEALTH HISTORY QUESTIONS EMPLOYEE & DEPENDENTS

1. ☐ Yes ☐ No Over the last five years, has any person to be insured incurred claims in excess of $5000?
2. ☐ Yes ☐ No Is any person to be insured receiving treatment, taking medication, or been advised of a condition that will require attention in the next 24 months (including pregnancy)? **If pregnant, is this a Multiple Birth pregnancy, i.e., twins, triplets? ☐ Yes ☐ No**
3. ☐ Yes ☐ No Has any person to be insured ever been diagnosed or treated for, HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex by a physician or member of the medical profession?
4. Within the past ten years, has any person to be insured ever had any symptoms, diagnosis, consultation, treatment, or taken any medication or received counseling for:

A. Alcohol/Drug Abuse ☐ Yes ☐ No
B. Arthritis/Back/Joint Disorder ☐ Yes ☐ No
C. Asthma ☐ Yes ☐ No
D. Autoimmune Disorder ☐ Yes ☐ No
E. Breast/Female Disorder ☐ Yes ☐ No
F. Cancer/Tumor ☐ Yes ☐ No
G. Colitis/Crohn's Disease ☐ Yes ☐ No
H. Congenital Disorder or Deformity ☐ Yes ☐ No
I. Diabetes ☐ Yes ☐ No
J. Digestive/Eating Disorder ☐ Yes ☐ No
K. Ear/Eye Disorder ☐ Yes ☐ No
L. Epilepsy/Seizures ☐ Yes ☐ No
M. Genital/Urinary Disorder ☐ Yes ☐ No
N. Heart/Blood/Vascular Disorder/ Stroke ☐ Yes ☐ No
O. Hemophilia ☐ Yes ☐ No
P. Hypertension/High Blood Pressure ☐ Yes ☐ No
Q. Kidney Disorder ☐ Yes ☐ No
R. Liver Disorder ☐ Yes ☐ No
S. Mental/Nervous Disorder ☐ Yes ☐ No
T. Muscle Disorder/ Neurological Disease ☐ Yes ☐ No
U. Pancreatic Disorder ☐ Yes ☐ No
V. Respiratory/Lung Disorder ☐ Yes ☐ No
W. Skin Disease ☐ Yes ☐ No
X. Systemic Lupus/Multiple Sclerosis ☐ Yes ☐ No
Y. Tobacco Product Use ☐ Yes ☐ No
Z. Transplants ☐ Yes ☐ No
AA. Tuberculosis or Hepatitis ☐ Yes ☐ No
BB. Currently Pregnant ☐ Yes ☐ No
CC. Auto Accident or Workers' Compensation Case Pending ☐ Yes ☐ No

5. List all medications prescribed by a physician in the last 12 months. Also, please indicate which medications any insured is **currently** taking: _____

*** * In the chart below, please provide details to ANY and ALL "Yes" answers from Questions 1-5.**

Question Number And Patient Name	Date of Onset	Diagnosis, Treatment, Or Reason For Medical Attention	Days In Hospital	Date Of Complete Recovery	Doctor/Address

IF SPACE PROVIDED IS INSUFFICIENT, PLEASE ATTACH SEPARATE SHEET OF PAPER, SIGNED AND DATED

Authorization to Release Information to DAKOTACARE

TO: Physicians, Hospitals and Other Providers of Health Care Services; Insurers; Employers; and Group Policyholders:

I request that you provide DAKOTACARE with any and all health, job status, or other information about me or any family member named on this application. I also request that you provide the above referred to information to the application department of any DAKOTACARE reinsurer requesting such information. Health information includes any and all records existing both prior to and subsequent to my application for health coverage with DAKOTACARE which may encompass: (a) my medical history; (b) my physical and mental health; and (c) my possible drug and alcohol use. Health information also includes any and all of the above referred to records which may be created or produced at any time in the future. The purpose of this release is to facilitate evaluation of my application, provide assistance in processing any claims submitted to DAKOTACARE, or for medical management programs and activities. A photocopy of this form is as valid as the original, and I may receive a copy of this form upon written request. This authorization is valid for the term of enrollment and this release is a waiver of any physician/patient privilege. I understand there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

Should DAKOTACARE become aware, at any time during the term of this Contract, that the Member or Enrolling Unit has committed fraud, or made an intentional misrepresentation of a material fact, on the Member's enrollment application, employer's application, or any application for individual health coverage completed for the benefit of the Member or any dependent or any other person applying for coverage, DAKOTACARE reserves the right to rescind such Contract pursuant to ARSD 20:06:55:14.

DAKOTACARE reserves the right to deny benefits under the Contract if it becomes aware during the term of the Contract, that the Member or Enrolling Unit has made fraudulent, or intentional misrepresentations, or any representations that materially affect the acceptance of the risk by DAKOTACARE, pursuant to SDCL 58-11-44, in any application for coverage from DAKOTACARE, or its affiliates.

Contract/Handbook Availability.

The undersigned employee/member acknowledges and understands that his/her employer/enrolling unit has been provided a copy of DAKOTACARE's Master Contract which the undersigned employee/member may consult at any time, and the undersigned employee/member can access the Member Handbook electronically at www.dakotacare.com or by contacting DAKOTACARE's Customer Service Department for a paper copy.

This application shall become a part of your DAKOTACARE contract.

X _____ X _____ X _____

Employee Signature | Date | Signature of Spouse (if you are applying for your spouse)

Authorization to Use Health Information for Life and Disability Insurance Purposes

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) including subsequent updates, DAKOTACARE may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates you are giving permission for the uses and/or disclosures described herein. You may revoke this authorization at any time by notifying DAKOTACARE in writing.

I hereby authorize DAKOTACARE's underwriting department to use health information provided on my health insurance enrollment form to provide life and/or disability insurance rates and coverage through my employer.

I understand I may revoke this authorization at any time by notifying DAKOTACARE in writing. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

This authorization is valid until group life insurance coverage is issued to me through my employer or for no more than one year from the date signed.

I understand I am under no obligation to sign this authorization. However, DAKOTACARE may not be able to release information or provide certain benefits without this authorization.

X _____ X _____

Employee Signature | Date