Employer Name:
Employee Name:

MMA HEALTH CARE PLAN & TRUST
MONTANA MEDICAL ASSOCIATION

APPLICATION AND / OR WAIVER OF COVERAGE

GINA/HIPAA HEALTH INFORMATION NOTICE

Pursuant to the requirements of the Genetic Information Non- Discrimination Act (GINA), the plan may not seek genetic information (including family medical history) from an individual prior to or in connection with their enrollment in the plan, or at any time for underwriting purposes. The health questions on this form are designed to obtain (non-genetic) information about manifested diseases or disorders with respect to each person seeking coverage under this plan (i.e. employees and family members who will be covered). 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 covered family members) more for coverage, based on health, than the amount charged a similarly situated individual. However, the health information being requested in this form may be used for underwriting on a group-by-group basis, and among classifications of similarly-situated individuals, in accordance with HIPAA and other applicable law.

Employee Name:

Date Completed:

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: Waiving Coverage

I decline to enroll in the health coverage for:

❑ Myself ❑ My Spouse ❑ My Dependent Child/Children (please list)

Reason for waiver: ❑ Other coverage _____(Plan name)

❑ Other reason (explain)_____

I understand that this waiver of coverage may affect the ability of each person listed above to obtain coverage prior to the next Open Enrollment Period unless a Special Enrollment Event occurs (such as loss of certain other coverage, marriage, birth, or adoption) and I notify the Plan, in accordance with the Plan terms.

EMPLOYEE'S SIGNATURE _____DATE SIGNED_____

SPOUSE'S SIGNATURE _____ DATE SIGNED_____
(If Spouse is waiving coverage)

Employee Name:

Date Completed:

Section 4: Other Health Insurance 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: ❑ Yes ❑ No	**Spouse** ❑ Yes ❑ No	**Child/Children** ❑ Yes ❑ No	
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:	Policy/Certificate Number:	Effective Date:	
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:

Section 5: 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:_____ Please explain any signs of complications: _____

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

1. ❑ AIDS	2. ❑ Alcohol Use	3. ❑ Blood or Coagulation Disorder	4. ❑Cancer
5. ❑ Chemotherapy/ Radiation	6. ❑Colon or Intestinal Disorder	7. ❑ Congenital Defect	8. ❑ Diabetes
9. ❑ Drug Use	10. ❑ Heart Problems	11. ❑ HIV Positive	12. ❑ Liver Disorder
13. ❑ Mental Disease	14. ❑ Nervous System Disorder	15. ❑ Rheumatic Fever	16. ❑ Seizure Disorder/ Epilepsy
17. ❑ Sleep Apnea	18. ❑ Stroke or Circulatory Problems	19. ❑ Tumor	20. ❑ Weight Loss Procedure (gastric bypass)

Condition Number (1-20)	Hospitalized? Yes or No	Name	Diagnosis	Dates (From/To)	Current Condition? Yes or No	Complete Provider/ Facility Name & Address

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

Condition Number (22-51)	Hospitalized? Yes or No	Name	Diagnosis	Dates (From/To)	Current Condition? Yes or No	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 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 6: 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.

Information regarding your insurability will be treated as confidential. **I hereby authorize** any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, institution or person, that has any records or knowledge of me or my health, to give to the Trust, or its third-party administrators, underwriters, or reinsurers, any such information. A photographic or facsimile copy of this authorization shall be as valid as the original.

Section 7: Signature

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

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Use if extra room was needed above

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