Please terminate the following employees benefits effective 10-1-2010

COLORADO UNIFORM EMPLOYEE APPLICATION FOR SMALL GROUP HEALTH BENEFIT PLANS

Employee Name:		Employer Name:	Magliocchetti, Inc.
Proposed Effective Date:	10-1-2010	Group Number (if known):	5H9273

This form is designed for an employee's initial application for coverage. Please contact your agent or the carrier to determine if this form should be used in other situations once the group is enrolled with the carrier.

EMPLOYEE & DEPENDENT INFORMATION

Employee Instructions: Please **type or print** using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought.

Last Name:		First Name:		Middle Initial:	
Social Security #:		Date of Birth: / /	Sex:	Height:	Weight:
Address:		City:			
County:		State:		Zip:	
Home Phone:		Email:		☐ Home	☐ Work
What is your job title at your current employer?		Work Phone:			
What was your first day of employment?		How many hours, on average, do you work each week?			
Are you (check one):	☐ Single ☐ Married	☐ Common Law*	☐ Legally Separated	☐ Divorced	☐ Widow or Widower
* A common law certification may be required by the carrier					
Are you on COBRA or State Continuation?	☐Yes ☐ No	Start Date:		Stop Date:	
Please select the type of coverage for which you are applying from the plans offered by your employer and issued by the carrier:					
Medical Plan Name:		Primary Care Physician Name:			
Primary Care Physician Address:					

List all dependents (spouse and child(ren)) applying for coverage. Please list the medical plan for which you are applying from the plans offered by your employer and issued by the carrier. If you need additional space, please use a separate sheet of paper and attach it to this application (please print your name and sign and date the additional sheet).

Spouse Name:		Relationship:	Spouse		
Social Security #:		Date of Birth: / /	Sex:	Height:	Weight:
Medical Plan Name:		Primary Care Physician Name:			
Primary Care Physician Address:					
Dependent Name:		Relationship:	☐Child ☐Stepchild ☐Other__________		
Social Security #:		Date of Birth: / /	Sex:	Height:	Weight:
Medical Plan Name:		Primary Care Physician Name:			
Primary Care Physician Address:					
Please check all that apply for the Dependent listed above*:					
☐ Full Time Student (Over Age 19 Under 24)	☐ Financially Dependent or Same Household (Over Age 19 Under 25)	☐ Disabled (Indicate reason) __________ (Over Age 19)			
Dependent Name:		Relationship:	☐Child ☐Stepchild ☐Other__________		
Social Security #:		Date of Birth: / /	Sex:	Height:	Weight:
Medical Plan Name:		Primary Care Physician Name:			

*If you check any of the boxes in this section the carrier may require additional information to determine eligibility of the dependent.

This section continued on the next page...

Employee Name:	Employer Name:

TERMS AND CONDITIONS

I acknowledge that I have read all sections of this Colorado Uniform Employee Application for Small Employer Group Health Coverage (Application), and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge. I understand and agree that neither my employer nor any insurance agents have any authority to waive my complete answer to any question, agree to insurability, alter any contract, or waive any Colorado small employer carrier's other rights or requirements.

I hereby apply for enrollment for myself and for my eligible family dependents listed. On behalf of my eligible family dependents and myself, I agree to all of the terms and conditions of the group contract(s) with Colorado small employer carrier(s) under which I wish to enroll for coverage. I have indicated in this Application, if required, what product(s) or provider(s) I have selected. **I agree that no coverage will be effective until the date specified by the Colorado small employer carrier(s) with whom I enroll, after this application has been accepted by such carrier(s).**

I understand and agree that any information obtained in connection with this Application will be used by Colorado small employer carrier(s) to determine eligibility for coverage, underwriting and for any other purposes related to providing coverage. On behalf of my eligible family dependents and myself, I authorize any provider of health services or supplies, insurance company, health care clearinghouse, pharmacy benefit manager, and any other person with knowledge or records to release information to any Colorado small employer carrier, its agents and legal representatives, about any and all health-related services and supplies provided or to be provided to me or my eligible family dependents.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

When applicable, I authorize my employer to deduct contributions from my earnings to be applied to the cost of coverage.

I agree to any applicable group contract provisions for the resolution of disagreements and disputes, including arbitration when required and as allowed by law. Please refer to any arbitration provisions in the group contract(s).

I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document will become a part of the contract when coverage is approved and issued.

Signature of Employee: ______________________ **Date Signed:** ____________