SUMMACARE

PO Box 3620
Akron, Ohio 44309-3620

ENROLLMENT APPLICATION (SMALL GROUP)

HOW TO ENROLL IN SUMMACARE:

Please use this page as a guide in completing your enrollment application. **If you have any questions, please call SummaCare Customer Service at 330-996-8700 or 800-996-8701.**

- PLEASE PRINT OR TYPE information requested.
- Complete ALL information that is requested by "Employee". Applications that are incomplete may cause a delay in processing.
- If adding an adult child between the ages of 19-28, additional information may be requested to determine eligibility.
- **MAKE SURE YOUR SPOUSE SIGNS THE APPLICATION (if applicable).**

IMPORTANT: PLEASE ALSO FILL OUT THE MEDICAL HISTORY QUESTIONNAIRE EVEN IF YOU ARE WAIVING HEALTHCARE COVERAGE AT THIS TIME.

WAIVER OF COVERAGE

COMPLETE THIS SECTION ONLY IF YOU ARE ELIGIBLE FOR GROUP COVERAGE AND CHOOSE NOT TO ENROLL FOR HEALTHCARE COVERAGE. ALSO, INDICATE IF YOU ARE WAIVING LIFE INSURANCE COVERAGE THROUGH SUMMACARE.

NAME		**DATE OF BIRTH**	
SS#		**DATE OF HIRE**	
ADDRESS		**CITY, STATE, ZIP**	
PHONE NUMBER		**EFFECTIVE DATE**	
EMPLOYER (GROUP) NAME/NUMBER			

REASON COVERAGE IS BEING WAIVED	☐ Have other coverage through spouse
	☐ Enrolled with SummaCare through another Employer Group (If so, contract #_____)
	☐ Enrolled in Group coverage through another employer-sponsored plan (If so, name of Insurance _____)
	☐ Other

I also wish to waive life insurance coverage through SummaCare:	☐ YES ☐ NO ☐ N/A
I have had an opportunity to enroll in SummaCare and hereby waive coverage available through this employer group.	
Employee Signature	Date

SUMMACARE

SUMMACARE ENROLLMENT APPLICATION
SMALL GROUP

BENEFITS OFFICES SHOULD SEND COMPLETED FORM TO ELIGIBILITY:
MAIL: PO BOX 3620 Akron, OH 44309-3620 EMAIL: EnrollmentACTs@summacare.com
FAX: 330-996-8953

TO BE COMPLETED BY THE EMPLOYER - FAILURE TO COMPLETE ALL SECTIONS MAY DELAY ENROLLMENT

COVERAGE EFFECTIVE DATE	HIRE DATE	DATE RECEIVED BY EMPLOYER
GROUP NUMBER	DIVISION NUMBER	BENEFIT PLAN
EMPLOYEE CLASS ☐HOURLY ☐SALARY ☐OHIO LAW ☐COBRA ☐RETIREE ☐MEDICARE WRAP	TYPE OF PLAN ☐PPO_____(Underwritten by Summa Insurance Company) ☐QUALIFIED PLAN ☐HSA ☐HRA ☐OTHER_____	
QUALIFYING EVENT: ☐NEW HIRE ☐REHIRE ☐OPEN ENROLLMENT (RENEWAL MONTH_____) ☐LOSS OF COVERAGE (PLEASE INCLUDE CERTIFICATE OF CREDITABLE COVERAGE WITH APPLICATION) ☐OTHER _____		

TO BE COMPLETED BY EMPLOYEE - RETURN TO YOUR BENEFITS OFFICE
DO NOT SEND DIRECTLY TO SUMMACARE

EMPLOYEE NAME		SOCIAL SECURITY NUMBER		
TYPE OF COVERAGE SELECTED (CHECK ONE): ☐SINGLE ☐EMPLOYEE & SPOUSE ONLY ☐EMPLOYEE & CHILDREN ONLY ☐FAMILY				
ADDRESS NUMBER & STREET	CITY	STATE	ZIP CODE	COUNTY
HOME PHONE # ( )	WORK PHONE # EXT. ( )	EMAIL ADDRESS		
MARITAL STATUS : ☐SINGLE ☐MARRIED ☐DIVORCED ☐LEGALLY SEPARATED ☐WIDOWED				
ALL INFORMATION BELOW REGARDING LANGUAGE AND RACE IS OPTIONAL				
PREFERRED SPOKEN LANGUAGE	PREFERRED WRITTEN LANGUAGE	RACE		

ONLY COMPLETE THE FOLLOWING INFORMATION FOR ALL PERSONS TO BE COVERED, INCLUDING YOURSELF. Using the SummaCare Provider Directory, please list the name of your Primary Provider for each person to be covered. If the address of any of the following individuals is different from the address above, please list the name and address on a separate sheet and attach them to this form.

SOCIAL SECURITY NUMBER (REQUIRED FOR ALL ENROLLING)	LAST NAME	FIRST NAME	MI	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH	SEX (M/F)

IF ADDING AN ADULT CHILD BETWEEN THE AGES OF 19-28, ADDITIONAL INFORMATION MAY BE REQUESTED TO DETERMINE ELIGIBILITY.

PROVIDER INFORMATION Information is not required but will assist in managing your care. Please complete only for those individuals enrolling.			
NAME	PRIMARY PHYSICIAN NAME	CODE	ARE YOU A NEW PATIENT (Y/N)

COORDINATION OF BENEFITS INFORMATION	
Have you been covered under any other health plan within the last 12 months?	☐ No ☐ Yes
If yes, please provide a copy of the Certificate of Creditable Coverage from the prior carrier stating the coverage effective and end dates. NOTICE - If this form is not received, enrollment and/or claims payment can be held up.	

ARE YOU OR YOUR DEPENDENTS CURRENTLY COVERED BY OTHER HEALTH INSURANCE? ☐ NO ☐ YES
If "yes" please complete the following information:

INSURANCE COMPANY NAME & ADDRESS	POLICY HOLDER NAME / DATE OF BIRTH	EFFECTIVE DATE OF POLICY	NAMES OF COVERED FAMILY MEMBERS	GROUP #	COVERAGE TYPE

☐ CHECK HERE IF YOUR SPOUSE IS CURRENTLY ELIGIBLE FOR HEALTH INSURANCE COVERAGE THROUGH HIS/HER EMPLOYER.

MEDICARE ELIGIBILITY

Complete this section if you or your dependents are covered by Medicare Part A and/or B.

NAME OF COVERED PERSON	MEDICARE #	CHECK WHICH PARTS	EFFECTIVE DATES FOR PART A/B
		☐ Part A ☐ Part B	
		☐ Part A ☐ Part B	

EMPLOYEE MUST SIGN AND DATE THE FOLLOWING CERTIFICATION AND AUTHORIZATION: By electing SummaCare, I understand that I and all my eligible dependents accept the SummaCare option in lieu of the benefits provided by my employer's other medical benefits plans. I certify that all information supplied on this form is true and complete to the best of my knowledge. I understand that all benefits for myself and my eligible dependents will be provided in accordance with the plan documents. I am familiar with and agree to abide by the terms and conditions governing membership and receipt of health services in the plan and agree to the provisions stated on the reverse side of this form, which I have read and understand.

EMPLOYEE SIGNATURE _____ DATE_____

SPOUSE (If applying for coverage) _____ DATE_____

SPOUSE MUST SIGN APPLICATION IF APPLYING FOR COVERAGE OR APPLICATION WILL NOT BE ACCEPTED.

MEDICAL HISTORY QUESTIONNAIRE

EMPLOYEE NAME: _____ **SOCIAL SECURITY NUMBER:** _____

1. **COMPLETE THE FOLLOWING INFORMATION FOR ALL PERSONS (APPLICANTS) APPLYING FOR COVERAGE.** For purposes of the following medical questions, the term "medical or social practitioner" includes but is not limited to: a doctor, nurse, psychologist, social worker, chiropractor, podiatrist, optometrist, osteopath, Christian Science practitioner, or a person affiliated with a self-help program such as Alcoholics Anonymous, a substance abuse program or weight loss program

2. Have you or any of your listed dependents been diagnosed or treated in the past five years by a medical or social practitioner for any of the following conditions? (see below) ☐ Yes ☐ No **If "yes", please check condition(s) that apply and explain in chart below:**

	Condition	Y		Condition	Y
1.	Acquired Immune Disorder (AIDS/HIV/Lupus)	☐	**14.**	Diabetes or Sugar in Urine (last 3 blood sugars and date) 1. 2. 3.	☐
2.	Alcohol or Drug Dependency	☐	**15.**	Eye, Ear, Nose, Throat Disorder (Cataracts, Blindness, Deafness)	☐
3.	Alzheimer's Disease or Memory Loss	☐	**16.**	Gall Stones, Kidney Stones, Kidney/Urinary Problems or Disorders	☐
4.	Anemia, Stroke, Hemophilia, Bleeding Problems or Disorders	☐	**17.**	High Blood Pressure (last 3 readings) 1. 2. 3.	☐
5.	Anorexia/Bulimia	☐	**18.**	Lupus	☐
6.	Arthritis (Osteo, Rheumatoid ,etc.) Or Gout	☐	**19.**	Multiple Sclerosis, Spina Bifida, Paralysis, Parkinson's Disease, Cerebral Palsy, Epilepsy, Seizures or Other Neurological Disorders	☐
7.	Asthma, Chronic Bronchitis, Emphysema, Tuberculosis or Other Lung Disorders	☐	**20.**	Muscular Dystrophy	☐
8.	Attempted Suicide, Depression or Other Nervous/Emotional Problems	☐	**21.**	Organ Recipient/Transplant	☐
9.	Cancer/Leukemia/Lymphoma/Melanomas or any Other Disease of the Skin	☐	**22.**	Pancreatitis or Pancreas Disorder	☐
10.	Cirrhosis of Liver or Other Liver Problems or Disorders	☐	**23.**	Scoliosis, Back Strain/Sprain, Bodily Deformities or Disabilities	☐
11.	Congenital Disease/Defect	☐	**24.**	Thyroid, Goiter, Gallbladder or Prostate Disease or Problem	☐
12.	Crohn's Disease/Ulcerative Colitis, Intestinal Polyps, Diverticulitis, Stomach, Ulcer or Other Bowel/ Stomach Problems or Disorders	☐	**25.**	Tumors/Growths/Cysts	☐
13.	Cystic Fibrosis	☐	**26.**	Other	☐

3. Has future surgery, diagnostic testing or medical treatment been recommended for anyone applying for coverage, excluding AIDS or HIV?
☐ Yes ☐ No **If "yes", please explain in chart below.**

4. Are you or any of your listed dependents pregnant? ☐ Yes ☐ No **If yes, due date:** _____

5. Has anyone applying for coverage been prescribed medication within the last 12 months? ☐ Yes ☐ No
If "yes", please list the mediations and dosages in chart below.

6. Has any insurance company refused or restricted health coverage for you or any of your listed dependents within the last 5 years?
☐ Yes ☐ No
If yes, please explain: _____

7. Do you or any of your listed dependents have a condition covered by Workers' Compensation? ☐ Yes ☐ No
If yes, please list condition and the Workers' Compensation number: _____

8. Do you or any of your listed dependent's smoke? ☐ Yes ☐ No **If yes, who any how many packs/day?** _____

#	Patient's Name	Condition, Diagnosis & Type of Treatment	Medications & Dosages	Date(s) of Treatment(s)	Hospitalized? (Y/N)	Recovered? (Y/N)

WARNING: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE OR SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

PLEASE REMOVE AND KEEP THIS PAGE

TERMS AND CONDITIONS

a. You understand that you are responsible for reporting to your employer, within 31 days, any changes in your employee status, in the number of your eligible dependents, in your spouse's employer health coverage, or any change in your residence.

b. Any data shared with employer groups is not implicitly or explicitly member identifiable, unless the member involved provides specific consent. Self-Funded Employers requiring identifiable data are held to strict confidentiality standards that protect the data from internal disclosure for any use that would adversely affect members.

The release of information is personal to you and your underage dependents. You may not authorize release of personal health information for your spouse unless documented proof of power of attorney or guardianship is provided with the enrollment application. If your spouse is receiving health care coverage under this plan, he/she must sign the enrollment application authorizing the release of personal health information as stated above.

Personal health information may be released without your consent by order of a court with appropriate jurisdiction. SummaCare warrants that any other person and or/entity that receives information from SummaCare sign a confidentiality agreement which requires them to abide by and release information in accordance with SummaCare's confidentiality policies and procedures.

c. You authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, carrier's HMO or other organization, institution or person that has any knowledge of your health or the health of your spouse, dependents and/or eligible adult-age children as listed on this form to disclose such information to the extent permitted by law to the carrier(s) for the purpose of compiling an accurate evaluation of the medical information provided and to establish premium rates for the group.

d. You understand and acknowledge that this authorization extends to all medical records, including records which may contain information regarding treatment for physical and mental illness, alcohol/drug use and/or HIV-AIDS test results or diagnosis. You expressly consent to the release of such information.

e. You understand the authorization signed for the purpose of collecting information in connection with this application for an insurance policy shall remain valid for 30 months from the date shown on the previous page. You understand that you or your authorized representative is entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.

f. You understand and agree that SummaCare will rely upon the information provided in this application as the basis for establishing group premium rates for health care coverage. You acknowledge that you may be required to complete and sign an additional authorization form.

g. You agree that benefits payable on your account or your dependent's account under your employer's group medical benefit plan will be paid directly to the provider of care.

h. You understand that no benefits shall take effect until this application is approved for SummaCare participation. Upon acceptance, as soon as possible, a SummaCare identification card(s) will be issued to you as evidence of coverage hereunder. Upon termination all identification card(s) received must be destroyed.

i. If there is a payroll, disability or pension deduction for your enrollment in SummaCare, you authorize it to be made.

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330-996-8700
Out-of Area 800-996-8701
P.O. Box 3620
Akron, Ohio 44309
www.summacare.com

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