Bluegrass Family Health

651 Perimeter Drive, Suite 300, Lexington, KY 40517
Phone: 800-787-2680 Fax: 859-335-3750

Small Group Enrollment Form

Applicants should use this form to apply for coverage
(fill out completely in blue or black ink)

1	**EMPLOYER Complete this Section if Coverage Accepted**
Plan Option Selected	Rider
Effective Date	Hire Date

2 ENROLLEE INFORMATION (To be completed by Enrollee)

Social Security Number	Last Name	First Name, MI	Gender ☐ M ☐ F	Date of Birth (MM/DD/YY)

Mailing Address	City	State	Zip	County

Home Phone	Work Phone	Email Address

Type of Contract
☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed

Retired
☐ Yes ☐ No

Disabled
☐ Yes ☐ No

COBRA
☐ Yes ☐ No

IF YES
☐ COBRA/Continuation original start date:____________________

Number of months eligible for COBRA
☐ 18 ☐ 29 ☐ 36

Employer

3 DEPENDENT INFORMATION – List dependents applying for coverage

Relationship of Eligible Dependents	Full Name (Last, First, MI)	Date of Birth (MM/DD/YY)	Gender (Check One)	Height	Weight	Social Security Number
Spouse			☐ M ☐ F			
Child 1			☐ M ☐ F			
Child 2			☐ M ☐ F			
Child 3			☐ M ☐ F			

Use a separate form for additional Dependents. For Dependents Age 19 and over proof of full-time student status may be required according to the coverage purchased by your employer. (does not apply to Tennessee domicile groups).

4 PRIOR COVERAGE (This section must be completed)

Have you or any dependents been covered by another health insurance plan at any time during the last 12 months? ☐ Yes ☐ No

a. Name of Insured ____
Name of Prior Employer Providing Coverage ____
b. Type of Contract: ☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family
c. Insurance Company Name ____
Effective Date ___________________________ Termination Date ___________________________

5 OTHER HEALTH COVERAGE (This section must be completed)

Is your spouse employed? ☐ Yes ☐ No Employer ____
On the day your coverage begins, list family members, including yourself, who will be covered by Bluegrass Family Health and any other health coverage including Medicare or retiree benefits____

____

Insurance Company Name _________________________________ Policy Number _______________________
Effective Date __________________________ Does this include a prescription benefit? ☐ Yes ☐ No

All statements and descriptions contained within this form shall be deemed representations and not warranties. KRS§304.14-110

Small Group Enrollment Form

Bluegrass Family Health

651 Perimeter Drive, Suite 300
Lexington, KY 40517
Phone: 800-787-2680 Fax: 859-335-3750

Employer	Applicant Last Name	Applicant First Name, MI	Social Security Number	
TN ☐ 2-25 KY☐ 2-50		Occupation/ Job Title	Applicant Height	Applicant Weight

Individual Health Information

Please answer all of the following questions for yourself and any covered dependents.

Explain any YES responses in the box provided below. **YES NO**

1. Do you or any of your dependents regularly take medication? ☐ yes ☐ no
2. Are you or any of your dependents currently pregnant? If so, when is the expected date of delivery? ☐ yes ☐ no
3. In the last five (5) years have you or any of your dependents ever had or received treatment or been advised by a licensed physician of having:
   a. Any heart or circulatory disorder such as high blood pressure, anemia, chest pain, angina or aneurysm? ☐ yes ☐ no
   b. Any lung or respiratory disorder such as asthma, emphysema, COPD or bronchitis? ☐ yes ☐ no
   c. Any type of tumor or cancer such as melanoma, leukemia or lymphoma? ☐ yes ☐ no
   d. Any type of mental or nervous condition or alcohol or drug abuse, including professional counseling? ☐ yes ☐ no
   e. Back, joint, bone or muscle disease or disorder such as arthritis (rheumatoid or osteo), lupus, multiple sclerosis (MS) or rheumatism? ☐ yes ☐ no
   f. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Human Immunodeficiency Virus (HIV), any disease or disorder of the immune system or tested positive for AIDS virus? ☐ yes ☐ no
   g. Any nervous system disorder such as migraines, stroke, seizures, tremors, Parkinson's or Alzheimer's? ☐ yes ☐ no
   h. Colitis, Crohn's disease, diverticulitis, other colon problems, ulcers or stomach trouble or any type of liver problems or hepatitis? ☐ yes ☐ no
   i. Diabetes, pancreas disorder, gallstones, or gallbladder troubles, goiter or thyroid trouble or hernia? ☐ yes ☐ no
   j. Kidney problems, kidney stones, nephritis, kidney disease, urinary tract disorder or the need for dialysis? ☐ yes ☐ no
   k. Any problems with male or female organs, prostate or gynecological problems or infertility? ☐ yes ☐ no
   l. Allergies, hay fever, sinus infection or a disorder of the eyes, ear, nose or throat? ☐ yes ☐ no
   m. History of an organ transplant, on a transplant waiting list or has a transplant been suggested? ☐ yes ☐ no
4. Have you or any of your dependents been told by a licensed physician that you may need a procedure, treatment, test, therapy or surgery in the future? ☐ yes ☐ no
5. Have you or any of your dependents smoked or used tobacco products within the last two (2) years? ☐ yes ☐ no

Explanation of YES Responses. Attach a separate sheet of paper if necessary.

Quest #	Name of Individual	Diagnosis/ Condition	Treatment	Medication	Onset Date	Date(s) of Treatment	Hospitalized (Y/N)	Surgery (Y/N)	Recovered (Y/N)
					/ /	/ /			
					/ /	/ /			

TERMS AND CONDITIONS

- I understand that I am responsible for promptly reporting to my employer any changes in my marital status, my number of eligible dependents or change in my residence.
- I hereby authorize any hospital, physician, surgeon, or pharmacist to release any information requested by Bluegrass Family Health, Inc. (BFH) with respect to any claim of the delivery of medical care on behalf of myself or a covered dependent. A photocopy of this authorization will serve the same as the original. This authorization is not the same as a HIPAA Authorization.
- I agree that any medical benefits payable on my behalf under my employer's Group Medical Benefits Plan may be paid directly to the provider of care.
- I understand and agree that no benefits shall take effect until this enrollment/change form is approved by BFH. Upon such acceptance, BFH shall as soon as possible, issue an identification card(s) to me.
- I authorize my employer to make the necessary deductions from my pay or any disability or retirement annuity benefits to which I may be entitled under any group plan sponsored by my employer while I am enrolled in BFH until this authorization is revoked by me in writing.
- I understand that I must be actively at work on the effective date of coverage or the effective date will be on the date I return to work, unless my absence is due to a medical condition.
- It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage. (TN) TCA§56-53-111
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent act, which is a crime. KRS§304.47-030
- It is additionally a crime to knowingly or intentionally obtain, possess, transfer, or use the identifying information of another person with intent to harm or defraud another person or entity, including with the intent to fraudulently obtain or attempt money, credit, goods, services or medical information in the name of another person without that person's consent. Penalties include imprisonment fines and denial of insurance benefits. KRS§514.160; (TN) TCA§39-14-150.

Applicant Name (print)________________________**Applicant Signature**______________________________**Date**_______