10421 South Jordan Gateway
Suite 400
South Jordan, UT 84095

LARGE GROUP (51+) ENROLLMENT FORM

HMO:	Plus (POS):	
❑ Mountain	❑ Peak Plus	❑ Dental
❑ Peak	❑ Peak Plus Traditional	❑ Other: ____________
❑ Peak Traditional	❑ Peak Plus Extended	____________
❑ Peak QHDHP	❑ Peak Advantage	____________
	❑ Peak Plus QHDHP	

For Office Use Only
Group No. ________
Effective Date ________
PEC: ________
____
New Hire Waiting Period ________

A. - EMPLOYER INFORMATION

Employer: ________________ Hire Date: ________ Rehire Date: ________

Location: ________________________ Is this a division? ❑Yes* ❑No

*If "Yes," Name of parent company: ________________________

Coverage	Self	Spouse	Child(ren)	COBRA	State Cont. Coverage	EFFECTIVE DATE
Medical	❑	❑	❑	❑	❑	________
Dental	❑	❑	❑	❑	❑	________

B. - EMPLOYEE

- ❖ **Mountain:** You must designate each family member's Primary Care Provider (PCP) and provider code. The provider code is the 6-digit number in parentheses next to each PCP in the Altius Provider Listing. All care must be received or arranged through your PCP.
- ❖ **All Peak Plans & Dental:** PCP designation is not required. Please refer to the Altius Provider Listing for participating providers.
- ❖ **All Plans:** If covering dependent(s) due to court order, attach copy of court documentation. Please include address and telephone number, if different from subscriber's: ________________________

Name Last: ____________ First: ____________ MI: ____ Job Title: ____________ Hours per Week: ______

Marital Status: ❑ Divorced ❑ Married ❑ Single ❑ Widowed E-Mail Address: ________________

Address: ________________ Apt. #: ______ City: ____________ State: ______ Zip Code: ______

Home Phone: (_____) ____________ Business Phone: (_____) ____________

Spouse's Employer: ____________ Spouse's Business Phone: (_____) ____________

C. - OTHER HEALTH COVERAGE — *fully complete sections C and D*

Do you or your dependent(s) have other health insurance? ❑ No ❑ Yes – what coverage? ❑ Medical ____________ (Name of carrier) ❑ Rx ❑ Medicare

Other Carrier's Phone: (____) ______ Policyholder's Name: ____________ Policy #: ______ Effective date of coverage: ______

If this coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care insurance so that Altius can determine whose coverage is Primary.

If other coverage is Medicare or Medicaid, are you or any of your dependents disabled? ❑ No ❑ Yes – Indicate name ____________

D. - PRIOR HEALTH COVERAGE — *fully complete sections C and D*

Have you or your dependent(s) had prior health insurance? ❑ No ❑ Yes – what coverage? ❑ Medical ____________ (Name of carrier) ❑ Rx ❑ Medicare

When was the last date that you were insured? ____________ Effective date of coverage: ____________ Term Date: ____________

Prior Carrier's Phone: (_____) ____________ Policyholder's Name: ____________ Policy #: ____________

Note: If you have had health care coverage within the last 63 days, your Pre-Existing Condition (PEC) waiting period limitation may be partially or completely waived. To determine if this applies to you, you must enclose proof of prior coverage, such as a Certificate of Creditable Coverage from your previous carrier.

Submission of prior coverage information does not automatically waive any Pre-Existing Condition Limitation. However, failure to provide proof of prior coverage will result in an automatic Pre-Existing Condition Waiting Period of up to 12 months.

E. - SUBSCRIBER/SPOUSE/DEPENDENTS – attach separate sheet if necessary

Social Security #	Office use only	Name - Last First MI	Date of Birth	Age	M/F	PCP Designation (Mountain only): Primary Care Physician (PCP) Name	PCP Code	Other Coverage (circle all that apply): Medical	Rx	Medicare
1)		Self						Y or N	Y or N	A or A&B
2)		Spouse						Y or N	Y or N	A or A&B
3)		Dependent						Y or N	Y or N	A or A&B
4)		Dependent						Y or N	Y or N	A or A&B
5)		Dependent						Y or N	Y or N	A or A&B
6)		Dependent						Y or N	Y or N	A or A&B

E. - AGREEMENT AND AUTHORIZATION

I have read and fully understand the Agreement and Authorization on the reverse side of this document and agree to its terms.

Subscriber Signature: ________________________ Date: ____________

Note: Did you fill in Social Security Number(s), physician name(s) and physician code(s)? IMPORTANT: INCOMPLETE INFORMATION WILL DELAY ENROLLMENT. If you have any questions regarding this enrollment application, please call the Customer Service office at 323-6200, or toll free at 800-377-4161.

Agreement and Authorization

I hereby apply for membership with Altius Health Plans (Altius) for the persons listed on this enrollment form (collectively referred to as Enrolled Family). I understand that my enrollment and benefits are in accordance with and described in the applicable Evidence of Coverage and Group Service Agreement. I authorize 1) all health providers and insurers to furnish Altius, and 2) all health providers and Altius to furnish all insurers and health providers records concerning me or any member of my Enrolled Family for whom information is requested for any purpose required for the coverage of benefits including, but not limited to, the coordination of payments with other insurers or in connection with the provision of medical care. I understand that I or my authorized representative may receive a copy of this form containing this authorization for disclosure of information. A photographic copy of this authorization shall be valid as the original. I authorize my employer to deduct from my wages the amount required (if any) to cover my contribution for coverage. I certify that all the above information is correct. For claim adjudication purposes, this authorization is valid for the duration of my coverage for health benefits through Altius. For purposes of collecting information for an insurance policy application, policy reinstatement, or a request for change in policy benefits, this authorization shall remain valid for 30 months from the date the authorization is signed.

I understand that if I and/or my dependent(s), if any, waive coverage, I may not again be eligible for coverage until the next open enrollment period, which is established by my employer and Altius. I also understand that unless I am declining enrollment for myself and my dependent(s) (including my spouse) because of other health insurance coverage, I may be subject to a pre-existing condition waiting period of up to 12 months, as specified by Altius. If I am waiving because I have other insurance, I realize that I may in the future be able to enroll myself and any dependent(s), provided that I request enrollment within 30 days after my other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependent(s) provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

By signing this form, I agree on behalf of myself and my Enrolled Family that Altius may use or disclose to third parties the information contained on this enrollment form and individually identifiable health information relating to my Enrolled Family for purposes of administering my health insurance benefits including treatment, payment, or health care operations, as those terms are explained in detail in the Altius Notice of Privacy Practices and to the extent permitted by law. My Enrolled Family's consent includes agreement for the use or disclosure of health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness, including substance abuse, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV). By signing this form, I also agree on behalf of myself and my Enrolled Family, to the extent permitted by law, health care providers, insurers, claims administrators, employers, and others may disclose my Enrolled Family's personal information including individually identifiable health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness including substance abuse, AIDS, ARC, or HIV to Altius for administration of health insurance benefits including treatment, payment, or health care operations purposes and other purposes permitted by law. I have read and agree to the statements above.