Igo Oil Field Service, Inc.

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Have you had prior health insurance coverage?
YES OR NO

If so, how long did you have coverage (Approximately?)

When did it expire?

Who was the carrier?

Great-West
HEALTHCARE

Benefit Plan Enrollment/Change Form

ENROLLING

Enrollment for:
- ☐ Myself and my dependents (family coverage)
- ☐ Myself only (single coverage) because:
  - ☐ I have no dependents
  - ☐ My dependents have other insurance
  - ☐ I don't wish to purchase dependent coverage

Plan Selections:

Medical	Ee	Ee & Sp	Ee & Ch	Family
PPO	☐	☐	☐	☐

DECLINING COVERAGE

Reason:
- ☐ I have other insurance
- ☐ I don't wish to purchase coverage

CHANGING INFORMATION

- ☐ Updating General Information
- ☐ Transferring to a different plan
- ☐ Changing PCPs
- ☐ Adding a dependent
- ☐ Changing FBA salary redirection amount

General Information (always complete this section)

Name Last First MI

Occupation

Street

Daytime Telephone ( )

Evening Telephone ( )

City State Zip Code

Email address

County

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Date of Marriage ___/___/___

Social Security Number

Life Insurance

If your employer is paying the full cost for this coverage, you are automatically covered under this benefit.

Beneficiary	Relationship	%
1.		
2.		
3.		

If you are applying for any Great-West coverage, including life coverage, you must answer the following question. You will not be individually denied coverage, or be charged different rates as a result of your answer. This information is not required if you are **only** applying for HMO medical coverage.

During the last 24 months, have you or any dependents been diagnosed with, or treated for, any adverse health conditions, including cancer, heart, lung, kidney, or liver diseases, diabetes, AIDS, ARC, brain disorders, or received an organ transplant, or incurred medical expenses which accumulated to more than $10,000 or been scheduled for surgery or an organ transplant? ☐ Yes ☐ No Condition?

For all Coverages

Name (Last, First, M.I.)	Date of Birth/ Relationship	Sex	Full-time Student		
Self	/ /	☐ M ☐ F			
Spouse	/ /	☐ M ☐ F			
Social Security Number					
Child	/ /	☐ M ☐ F	☐ Yes ☐ No		
Social Security Number					
Child	/ /	☐ M ☐ F	☐ Yes ☐ No		
Social Security Number					
Child	/ /	☐ M ☐ F	☐ Yes ☐ No		
Social Security Number					

By my signature below, I acknowledge that I have read and understand the disclosure on the back of this application. I authorize the required payroll deduction for contributory benefits. I also represent that all information shown on this application is correct.

Employee Signature | Date (MM/DD/YYYY)

To be Completed by Employer

Company Name
IGO Oil Fields

Date of Full-time Employment | Div/Location

Orig. Eff. Date of EE's Coverage | Orig. Eff. Date of Dep.'s Coverage

Earnings $_____
- ☐ Hourly ☐ Weekly ☐ Monthly
- ☐ Bi-monthly ☐ Yearly

Hours worked per week? _____

Is employee/dependent on COBRA continuation?
☐ Yes ☐ No

If Yes, attach copy of original COBRA enrollment form.

For Company Use Only

Plan Number		Effective Date
Division	Late App	Class/Benefit Group

Disclosure Information

I hereby apply for all non-contributory coverages under my employer's plan and any contributory coverages that I have elected on the front of this application.

Life and/or disability income coverage

I understand that I must satisfy the eligibility and actively at work requirements at my employer's usual place of business on the date coverage for myself and any eligible dependents becomes effective. If I am not actively at work, I understand that coverage for myself and life coverage for my eligible dependents may not become effective until I return to work. I will be considered a late applicant if I decline any contributory coverage offered under this application and later apply. As a late applicant applying for coverage, I understand that proof of good health may be required for myself and eligible dependents.

FBA Coverage

If I have elected to redirect money for eligible dependent care expenses, I have considered the IRS tax credit available to me. I understand that if I am married and filing a separate tax return, a lower maximum applies.

Health coverage

I understand that I must submit a Certificate or evidence of prior creditable coverage to receive credit towards the satisfaction of any pre-existing condition limitation specified in my employer's plan; and to be eligible for credit, the gap between the two coverages must be 62 days or less.

I and/or my eligible dependent(s) will be considered a *"Special Applicant"* if:

- I did not previously elect to cover myself and/or my eligible dependent(s) under my employer's policy/plan because of other health coverage and I later apply because the other coverage terminated involuntarily; or
- I did not previously elect to cover myself and/or my eligible dependent(s) and I later apply for coverage because of a change in my family status resulting from marriage, birth or adoption of a child.

I understand that to qualify as a *"Special Applicant"* I must apply for health coverage for myself and/or my eligible dependent(s) within 31 days after:

- Coverage under the prior health plan ends; or I marry; or I acquire a new child through birth, adoption or placement of a child for adoption.

I understand that health coverage is available to me and that I may experience special requirements if I do not enroll at this time. I will be considered a late applicant if:

- I fail to qualify as a *"Special Applicant"* because I did not apply within the 31 days as specified above; or
- I did not previously elect to cover myself and/or my eligible dependents and I later apply.

As a late applicant applying for health coverage, I realize that I may only be allowed entrance to the plan during the open enrollment period. As a late applicant, I realize that my entry to the plan may be subject to special enrollment requirements and that I must contact my Plan Administrator for details.

For all coverages

I hereby authorize any insurance company, health care provider, or other entity or person having knowledge of anyone listed on this application to give this new carrier or their designated agent(s) any and all records pertaining to such person's medical history for purposes of review, investigation or evaluation. For application purposes, this authorization is valid for 30 months from the date I sign it. For purposes of claims, reimbursement and receipt of services rendered, this authorization is valid during the term of such person's coverage for evaluation of the nature and medical necessity of the services received. I am, or my authorized representative is, entitled to a copy of this signed authorization.

California residents – I understand that any differences between myself (and/or my dependents) and One Health Plan, including any claim of medical malpractice, will be resolved through One Health Plan's grievance process, up to and including binding arbitration. Under this coverage, both the member and One Health Plan are giving up the right to have differences decided by jury trial or by a court, except as state law provides for judicial review of arbitration proceedings. Any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Colorado residents – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company 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.

New Jersey residents – Different providers in our network have agreed to be paid in different ways by us. Your provider may be paid each time she or he treats you (fee for service). These payment methods may include financial incentive agreements to pay some providers more (bonuses) based on many factors; member satisfaction, quality of care, and control of costs and use of services among them. If you desire additional information about how our primary care physicians or any other providers in our network are compensated, please call Member Services at the telephone number shown in your enrollment kit.

Florida residents – (1) I have received educational material regarding Advance Directives from One Health Plan of Florida, Inc. as required by state regulations. I understand that if I wish to have Advance Directives I need to contact my primary care physician and supply him/her with a copy of my wishes. I can receive more education about Advance Directives by contacting my primary care physician. (2) Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Residents of all other states – Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

This Disclosure Information forms a part of the *Application for Membership* as fully as if it were contained over the applicant's signature.

Great-West℠ HEALTHCARE

Pre-Sale Health Questionnaire

The information in this questionnaire will be solely used for the purpose of properly underwriting and administering the group coverage.
The employee will not be individually denied coverage or charged a different contribution as a result of the information provided in this questionnaire.

Part A - Employee and Dependent Information

	Full name	DOB	Height	Weight	COBRA	If yes, start date
Employee		/ /			Yes or No	/ /
Spouse		/ /			Yes or No	/ /
Domestic Partner*		/ /			Yes or No	/ /
Dependent		/ /			Yes or No	/ /
Children		/ /			Yes or No	/ /
		/ /			Yes or No	/ /

If domestic partner coverage is elected by the employer.

Part B - Health Information

*Please review and answer yes or no to conditions diagnosed, treated for or consulted on during the past **5 years** for each person listed above in Part A. If yes is marked, please provide additional applicable details.* ***If more space is needed, please attach the additional information on a separate page and sign the page.***

Cancer/ Tumors ☐ Lung ☐ Breast ☐ Colon ☐ Prostate ☐ Melanoma ☐ Leukemia/Lymphoma ☐ Other _____

☐ Yes ☐ No
Patient Name _____ Date Diagnosed ____/____/____ Date Last Treated ____/____/____
Stage/Level _____ Chemo/Radiation ☐ Yes ☐ No If Yes, Date Completed ____/____/____
Has the cancer metastasized beyond the primary site? _____
Surgeries completed? ☐ Yes ☐ No If yes, type of surgery and when? _____
If no, what further surgeries are expected? _____
List all medications, injections and infusions used to treat condition: _____

Heart/ Circulatory ☐ High Blood Pressure ☐ Stroke (*please see additional question below) ☐ Aneurysm ☐ Heart disease (provide diagnosis) ☐ Other _____

☐ Yes ☐ No
Patient Name _____ Date Diagnosed ____/____/____ Date Last Treated ____/____/____
Surgeries completed? ☐ Yes ☐ No If yes, type of surgery and when? _____
If no, what further surgeries are expected? _____
List all medications used to treat condition: _____
*If **Stroke** is selected, are there any residuals (complications) or special needs? _____

Intestinal/ Endocrine ☐ Crohn's/Ulcerative Colitis ☐ Diabetes ☐ Chronic Pancreatitis ☐ Hep C ☐ Colon Disorder ☐ Liver Disorder/Disease (please give diagnosis) _____ ☐ Other _____

☐ Yes ☐ No
Patient Name _____ Date Diagnosed ____/____/____ Date Last Treated ____/____/____
Organ Damage/Complications _____
Surgeries completed? ☐ Yes ☐ No If yes, type of surgery and when?
If no, what further surgeries are expected? _____
List all medications, injections and infusions used to treat condition: _____

Brain/ Nervous ☐ Multiple Sclerosis ☐ Cerebral Palsy ☐ Paralysis ☐ Other _____

☐ Yes ☐ No
Patient Name _____ Date Diagnosed ____/____/____ Date Last Treated ____/____/____
Complications or Special Needs? _____
Surgeries completed? ☐ Yes ☐ No If yes, type of surgery and when? _____
If no, what further surgeries are expected? _____
List all medications, injections and infusions used to treat condition: _____

Immune ☐ Lupus ☐ HIV + ☐ AIDS ☐ Other _____

☐ Yes ☐ No
Patient Name _____ Date Diagnosed ____/____/____ Date Last Treated ____/____/____
Organ Involvement/Complications? _____
List all medications, injections and infusions used to treat condition: _____

Respiratory ☐ Asthma ☐ Cystic Fibrosis ☐ Emphysema (COPD) ☐ Tuberculosis ☐ Sleep Apnea ☐ Other _____

☐ Yes ☐ No
Patient Name _____ Date Diagnosed ____/____/____ Date Last Treated ____/____/____
Complications? _____ Is patient on oxygen? ☐ Yes ☐ No
List all medications used to treat condition: _____

Eyes/Ears/ Nose/Throat
☐ Yes
☐ No

☐ Cleft Lip/Palate ☐ Retinopathy ☐ Other _____
Patient Name_____ Date Diagnosed____/____/____ Date Last Treated____/____/____
Surgeries completed? ☐ Yes ☐ No If yes, type of surgery and when? _____
If no, what further surgeries are expected? _____
List all medications used to treat condition: _____

Urinary/ Kidney
☐ Yes
☐ No

☐ Kidney Stones ☐ Neurogenic Bladder ☐ Reflux ☐ Polycystic kidney disease
☐ Chronic Renal Failure ☐ End Stage Renal Disease (ESRD) ☐ Other _____
Patient Name_____ Date Diagnosed____/____/____ Date Last Treated____/____/____
Medicare Eligibility Date (for ESRD)____/____/____ Expected Medicare Primary Date____/____/____
Dialysis start date____/____/____ Dialysis type/frequency _____
Surgeries completed? ☐ Yes ☐ No If yes, type of surgery and when?_____
If no, what further surgeries are expected? _____
Current Status and Level (%) of Kidney function (if applicable): _____
List all medications, injections and infusions used to treat condition: _____

Skeletal/ Muscle
☐ Yes
☐ No

☐ Arthritis (osteo or rheumatoid) ☐ Back or Neck disorder (provide diagnosis) _____
☐ Growth Hormone Deficiency/Dwarfism ☐ Spinal Bifida ☐ Other _____
Patient Name_____ Date Diagnosed____/____/____ Date Last Treated____/____/____
Surgeries completed? ☐ Yes ☐ No If yes, type of surgery and when?
If no, what further surgeries are expected? _____
List all medications, injections and infusions used to treat condition: _____

Transplant
☐ Yes
☐ No

☐ Organ_____ ☐ Bone Marrow (autologous or allogenic)_____
☐ Have you discussed a need for a transplant in the future? ☐ Yes ☐ No
Patient Name_____ Date Diagnosed____/____/____ Date Last Treated____/____/____
Transplant completed? ☐ Yes ☐ No If yes, when? ____/____/____ Signs of Rejection/Complications? ☐ Yes ☐ No
If not completed, is the patient on a list or is there an expected transplant date? _____
List all medications, injections and infusions used to treat condition: _____

Pregnancy
☐ Yes
☐ No

Current Pregnancy Due Date: ____/____/____ Multiples Expected ☐ Yes ☐ No
Is pregnancy considered high risk ☐ Yes ☐ No or have there been complications? ☐ Yes ☐ No
Medications: _____

Other
☐ Yes
☐ No

☐ Other condition or congenital disorder not mentioned above *(please provide details below).*
☐ Other testing, treatment or surgery discussed but not completed *(please provide details below).*
☐ Any medications or treatment therapy not mentioned previously_____
Patient Name_____ Date Diagnosed____/____/____ Date Last Treated____/____/____
Additional Details _____

I understand and agree that if I knowingly provided false information on this Pre-Sale Health Questionnaire, it may affect the payment of claims or result in termination of my/or my dependent's coverage.

Employer Name _____
(please print)

Employee Signature_____ Date____/____/____