



Enrollment Application

for small groups (with 2-50 eligible employees)

Please complete using black ink. Initial all corrections.

All questions must be answered.

Member Status Change

- Initial Enrollment Waiving coverage Benefit Change
- Special Enrollment* COBRA* Address Change
- Late Enrollment Additions/Terminations* PCP Change

Reason waiving coverage _____

*Complete Qualifying Event box below.

VHP VSF

Effective Date of Coverage	Employer / Group Name	Group Number	BA Initials
----------------------------	-----------------------	--------------	-------------

Employee Information

Social Security Number		Last Name		First Name		M.I.	Height	Weight
Address				Apt.	City		State	ZIP Code
Mailing Address (if different than above)				Apt.	City		State	ZIP Code
Home Telephone Number ()		Work Telephone Number ()		E-Mail Address		Birth Date		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Language Preference <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____		Date of Hire		Primary Care Physician (First and Last Name) <i>Existing Patient?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No		VISTA Provider ID Number (located in provider directory)		

Qualifying Event <i>**include legal documentation</i>		Product Selection	
Event date _____ <input type="checkbox"/> Marriage** <input type="checkbox"/> Adoption** <input type="checkbox"/> Pre-Enrollment (newborn)		<input type="checkbox"/> HMO <input type="checkbox"/> POS	
<input type="checkbox"/> Legal Guardianship** <input type="checkbox"/> Other _____		MHS# _____ MHS# _____	

Other Health Coverage
Will you or any of your dependents be covered by any other health coverage, including Medicare or Medicaid on the day your coverage begins? Yes No

If yes, indicate names of those to be covered: _____ Effective Date: _____ Policy #: _____

Insurance Co. Name: _____ Insurance Co. Address: _____ Insurance Co. Telephone #: _____

Prior Health Coverage
Have you been covered by any other health coverage within the last 12 months (or 18 months for late enrollees)? Yes No (If yes, Certificates of Creditable Coverage may be requested.)

If yes, indicate Insurance Co. Name: _____ Insurance Co. Address: _____ Policy #: _____

Insurance Co. Telephone #: _____ Effective Date: _____ Termination Date: _____ Reason for Termination: _____

Family Information
For dependent coverage, list each dependent below. Indicate additional dependents on a separate sheet. Except for dependents pursuing a full-time student status at an educational institution, college, university, vocational or secondary school, dependents must maintain their primary residence in VISTA's service area, or the dependent is not eligible for HMO coverage. ***If a dependent who is eligible for coverage has a different last name than that of the employee, you must attach copies of supporting documentation showing evidence of his/her dependent status (birth certificate, court order for guardianship, marriage certificate, etc.). If dependent is unmarried and age 19 or older, attach proof of (a) dependent status by providing a copy of your last IRS 1040 form, and (b) if student: a letter from registrar's office certifying current hours enrolled; or (c) if not a student but living in household: proof of legal residence (driver's license, etc.); or (d) disabled: a physician's certification stating date and degree of disability.

1	Dependent Last Name (if different***)			First Name		M.I.	Height	Weight
	Birth Date	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Primary Care Physician (First and Last Name) <i>Existing Patient?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No		VISTA Provider ID Number (located in provider directory)		
2	Dependent Last Name (if different***)			First Name		M.I.	Height	Weight
	Birth Date	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Primary Care Physician (First and Last Name) <i>Existing Patient?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No		VISTA Provider ID Number (located in provider directory)		
3	Dependent Last Name (if different***)			First Name		M.I.	Height	Weight
	Birth Date	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Primary Care Physician (First and Last Name) <i>Existing Patient?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No		VISTA Provider ID Number (located in provider directory)		
4	Dependent Last Name (if different***)			First Name		M.I.	Height	Weight
	Birth Date	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Primary Care Physician (First and Last Name) <i>Existing Patient?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No		VISTA Provider ID Number (located in provider directory)		
5	Dependent Last Name (if different***)			First Name		M.I.	Height	Weight
	Birth Date	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Primary Care Physician (First and Last Name) <i>Existing Patient?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No		VISTA Provider ID Number (located in provider directory)		

Social Security Number 	Last Name	First Name	M.I.
----------------------------	-----------	------------	------

Health Questionnaire

Complete all information accurately and in full. Answer all questions on behalf of all applicants applying for coverage including dependents. I certify that information and statements furnished by me are true and complete to the best of my knowledge. Complete details for all "YES" answers must be provided below.

1. Have you or any Applicant ever been a member of an individual or group plan by Vista Healthplan of South Florida, Vista Insurance Plan or any of their affiliates (i.e. Foundation Health, Vista Healthplan, Beacon Health Plans, or Healthplan Southeast)? Yes No
2. In the previous twelve months, have you or any covered dependent had an abnormal physical exam, laboratory results, diagnostic tests or been advised by a medical professional to have diagnostic tests, treatments, surgery or hospitalization, been a patient in a hospital, clinic, doctor's office, emergency room, surgicenter, sanitarium, or any other medical facility as an inpatient or outpatient, including childbirth? Yes No
3. Have you or any dependent ever tested positive for human immunodeficiency virus (HIV) or been diagnosed as having aids related complex / conditions (ARC), acquired immunodeficiency syndrome (AIDS) or any other medical condition / disorder derived from such infection or immunodeficiency? Yes No
4. Are you or any dependent currently pregnant? Yes No
5. Indicate below all prescribed medications taken within the last 12 months or currently being taken by you or a dependent listed on the Application.

(If you answered yes to any question above, please give specific information for each individual below.)

A	Name	Age	Condition		
	Dates of Treatment	Type of Treatment (including medication, if any)			
	Treating Physician's Name		Treating Physician's Address		
	City	State	ZIP	Office Phone # ()	
B	Name	Age	Condition		
	Dates of Treatment	Type of Treatment (including medication, if any)			
	Treating Physician's Name		Treating Physician's Address		
	City	State	ZIP	Office Phone # ()	
C	Name	Age	Condition		
	Dates of Treatment	Type of Treatment (including medication, if any)			
	Treating Physician's Name		Treating Physician's Address		
	City	State	ZIP	Office Phone # ()	
D	Name	Age	Condition		
	Dates of Treatment	Type of Treatment (including medication, if any)			
	Treating Physician's Name		Treating Physician's Address		
	City	State	ZIP	Office Phone # ()	
E	Name	Age	Condition		
	Dates of Treatment	Type of Treatment (including medication, if any)			
	Treating Physician's Name		Treating Physician's Address		
	City	State	ZIP	Office Phone # ()	

Social Security Number 	Last Name	First Name	M.I.
----------------------------	-----------	------------	------

Election of Coverage and Authorization

I understand that for traditional HMO/POS plans, referrals for specialty care and services, unless otherwise required by State or Federal law or in accordance with my Certificate of Coverage, must be coordinated by my primary care physician (PCP). Written referrals, if required must be provided by my PCP prior to seeing any specialist. I authorize any licensed physician, hospital, health care provider, insurer or any other medical or insuring entity in possession of my and my dependents' medical records and information, including any and all mental health records and information, to release my medical records and information and those of my dependents to the PCP and VISTA. This information may be requested after we are accepted by VISTA to identify possible pre-existing conditions. I hereby provide VISTA with consent to use identifiable information for general treatment, payment or health care operations, including but not limited to, coordination of care, quality assessment, utilization review, fraud detection or accreditation purposes. If member identifiable information is to be used for any other purpose, VISTA will obtain specific authorization from me and my dependents as required. I understand that newborns and adopted children, if adopted before the age of eighteen, are not subject to a pre-existing condition waiting period, if enrolled within 30 days but not later than 63 days after birth, adoption or placement. I agree that coverage for pre-existing conditions will not be provided until the specified waiting period indicated in VISTA's Certificate of Coverage or Group Master Contract is concluded. I understand that my dependents (if any) and I may be subject to a pre-existing condition exclusion until the required Certificate(s) of Creditable Coverage are received by VISTA. I certify that all information and statements furnished by me are true and complete to the best of my knowledge. I understand that any misrepresentation or omission of any information including pre-existing conditions, may result in the termination of my or my dependent's coverage. I understand that I am financially liable for any charges incurred after the effective date of termination of coverage. I hereby acknowledge VISTA's right to require proof of any dependent's or spouse's or child's dependent status. I understand that VISTA does not directly employ any participating providers or facilities. All health care providers and facilities are independent contractors and are not the agents or employees of VISTA. I agree that if my dependents or I have not been continuously covered by creditable coverage within the last 12 months (18 months for late enrollees), as applicable, my dependents and I, as applicable, may be subject to a pre-existing condition exclusion. If applying for HMO coverage, I certify that I maintain my primary residence in VISTA's service area or am regularly employed in the VISTA service area. I also certify that, except for dependents pursuing a full-time student status at an educational institution, college, university, vocational or secondary school, dependents must maintain their primary residence in VISTA's service area or the dependent is not eligible for HMO coverage and dependent children are dependent on me for support and maintenance. The Certificate of Coverage (or "Contract") can be obtained through (i) the VISTA website at www.vistahealthplan.com, (ii) by contacting your Group Benefit Administrator, or (iii) by calling the VISTA Customer Service Department at 1-866-VISTA-FL (1-866-847-8235) and requesting a hard copy of the Contract be mailed via U.S. regular mail. Your signature on this application represents acceptance of these delivery options.

I understand that 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 may be guilty of a felony of the third degree. VISTA may terminate coverage of any member who knowingly defrauds VISTA.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THIS APPLICATION.

X

Applicant Signature

Date