



**FOR GROUPS 2-50 (PROVIDE DETAILS TO ALL YES ANSWERS ON A SEPARATE SHEET OF PAPER)**

- 1.  YES  NO In the last 6 months, have you or any eligible dependents incurred claims in excess of \$2,500?
- 2.  YES  NO Is any person to be insured receiving treatment, taking medication, or been advised of a condition that will require attention in the next 6 months?
- 3.  YES  NO Has any person to be insured ever been diagnosed or tested for acquired immune deficiency syndrome (AIDS) or an AIDS related complex by a physician or member of the medical profession?
- 4.  YES  NO Within the last 6 months, has any person to be insured been diagnosed or had treatment for any of the following: Cancer/Tumor, Diabetes, Heart/Blood Vascular Disorder, Kidney Disorder, Liver Disorder, Respiratory Lung Disorder, Stroke, Systemic Lupus/Multiple Sclerosis, Transplants?

**5. List all medications you or any eligible dependents are currently taking: (N/A if no medications)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I wish to decline any coverage option. \_\_\_\_\_  
Signature Date

State reason for waiving coverage: \_\_\_\_\_

I declare all statements contained in this entire form are true and correct to the best of my knowledge and belief and that no material information has been withheld or omitted.

\_\_\_\_\_  
Initials Date

I hereby authorize any Physician, Medical Practitioner, Hospital, Clinic, Veteran's Administration Facility, other medical and/or medically related Facility, Insurance or Reinsurance Company, or Consumer Reporting Agency, to release to Evergreen Health Plan, Inc., or its legal representative, any and all such information as to diagnosis, treatment, and prognosis with respect to any physical or mental condition, including Drug or Alcohol abuse, and/or treatment of myself, spouse, or my minor children, and other non-medical information of myself, spouse, and/or my minor children. I understand that I may request a copy of this authorization at any time. I agree that a photographic copy of this authorization shall be as valid as the original.

\_\_\_\_\_  
Initials Date

I have received a copy of the Evergreen Health Plan, Inc. Managed Care Plan Acknowledgement and understand the plan provisions as stated.

\_\_\_\_\_  
Initials Date

I authorize my employer to deduct the necessary contribution toward the premium. I reserve the right to revoke this deduction authorization at any time upon my written notice. This application will be part of the contract. Coverage is effective only after approval by Evergreen Health Plan, Inc. and satisfaction of any probationary period.

Applicant Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

EVERGREEN HEALTH PLAN

POST OFFICE BOX 100 COLUMBUS, GEORGIA 31902-0100 TELEPHONE 706-660-6175 FAX 706-660-6515

**Evergreen Health Plan, Inc.**  
**Managed Care Plan Acknowledgement**

I understand that I am enrolling in a managed care plan, which requires that healthcare services must be provided by participating providers. Failure to use a participating provider will result in reduced coverage or no coverage for services that I receive, and I will be fully responsible for any and all costs not covered by Evergreen.

I have received or have access to a complete listing of the participating providers. I understand that the participation status of any provider may change from time to time. It is my responsibility to verify that my healthcare provider is participating with Evergreen Health Plan prior to receiving services. I may verify participation status via the Evergreen Health Plan website, [www.evergreenhealthplan.com](http://www.evergreenhealthplan.com), which is updated at least every 30 days. I may also verify status by contacting Member Services at 706-660-6550 or toll free at 888-294-9541.

As required by the State of Georgia regulations, the following is a summary of the financial arrangements with the health care providers who are participating in the Evergreen Health Plan network:

- 1) Hospital providers are paid according to a contract which includes inpatient per diems, case rates, and discounted fee for service arrangements depending on specific services provided.
- 2) Physicians are paid discounted fee for service in accordance with a specific fee schedule, which has been provided to them as contracted.
- 3) Laboratory services are provided through a capitated per member per month flat fee.
- 4) Other ancillary services including home health, skilled nursing, and hospice are paid on a contracted fee schedule with per diems or per visit amounts.