



Employee Enrollment / Refusal Form
For groups with 5 OR MORE EMPLOYEES electing medical coverage

HOME OFFICE USE ONLY -- AS	POLICY #:	LOCATION:	PLAN:	COV CLASS:	MED EFF: / /
EE COV CODE:	LIFE EFF: / /	LIFE VOL: \$	SPS VOL: \$	CHRN VOL: \$	WI VOL: \$
SPS COV CODE:	NEWBORN VOL: \$	DENTAL: (YES / NO) – ORTHO	DNT MAJ WP END DATE: / /	RX CARD: (RX / DISCOUNT)	VISION: (YES / NO)
CH COV CODE:	PC FROM: / /	THRU: / /	PC APPLIES TO: EE / SP / CH / FAM	WP ST DT / /	SIGNED: / /

INSTRUCTIONS FOR COMPLETING THIS FORM

1. **Misstatements and omissions made by you on this form may cause you to lose coverage under your employer's plan.**
2. This form must be completed by the **EMPLOYEE ONLY**.
3. Please **PRINT** in **BLACK INK** only and **INITIAL & DATE** all corrections.
4. You must be a US Citizen or Legal Alien residing in the USA to be eligible for coverage under this plan.

STEP 1: PLEASE TELL US ABOUT YOURSELF

Last Name		First Name		M.I.
Home Address		City		State Zip Code
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number - -		Birthdate / /	Marital Status (Please check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law
Height (ft / in):	Weight (lbs):	Do You Use Tobacco Products? <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____ Yrs Used: _____		
Home Phone ()	Work Phone ()	CHECK HERE <input type="checkbox"/> If you or any of your dependents are Legal Aliens residing in the USA. Please attach a copy of your Alien Registration Cards and/or legal work permits to the back of this form.		
What Company Do You Work For?		Your Work Address:	Email Address:	
Job Title:		Duties:	Hours Worked Per Week:	
Date Employed Full-Time / /	Employee Status (Please check one) <input type="checkbox"/> Active <input type="checkbox"/> Retiree (not eligible) <input type="checkbox"/> COBRA <input type="checkbox"/> Other Leave (Please explain)			
Effective Date of COBRA/Continuation/Other Leave (if applicable) / /	Earnings Basis (Please check one) <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly <input type="checkbox"/> Commission <input type="checkbox"/> Other (Please explain)			Annual Gross Earnings \$

STEP 2: PLEASE TELL US ABOUT YOUR FAMILY MEMBERS WHO ARE ELECTING COVERAGE
 Only your natural children, adopted children, and step-children, for whom you provide 50% of the support and maintenance, are eligible to enroll. If the child has a different last name or resides at a different address you must provide a copy of the birth certificate, child support order, divorce decree, or other documentation that conclusively shows the employee / dependent relationship.

Relation To Employee	Last Name (if different), First Name, M.I.	Gender (M/F)	Date of Birth	Social Security Number	Height (Ft/In)	Weight (lbs)	Tobacco User? (Y/N) Type/Yrs Used	For Full Time Students (Age 19 and over) Please provide the Name & State of the School
Spouse					/			
<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____					/			
<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____					/			
<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____					/			
<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____					/			
<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____					/			
<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____					/			

Does the spouse and/or dependent children named on this application live with you at the address shown above? Yes No

If "No", please list their full address.	Name	Home Address	City	State	Zip Code
	Name	Home Address	City	State	Zip Code

STEP 3: PLEASE TELL US WHAT COVERAGES YOU ARE ELECTING OR DECLINING FOR ALL FAMILY MEMBERS (even those not listed above) - Check "No" to decline a coverage						
PERSON	MEDICAL	DENTAL If elected by your employer	VISION If elected by your employer	LIFE AND AD&D	WEEKLY INDEMNITY If elected by your employer	DUAL HEALTH PLANS (If Applicable)
Employee	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> High (better benefits, higher cost) <input type="checkbox"/> Low (lesser benefits, lower cost)
Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Children	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
LIFE INSURANCE BENEFICIARY (Death benefits will be payable to your estate if no beneficiary is listed below):						
Name:			Relationship:			

STEP 4: PLEASE TELL US WHY YOU ARE DECLINING COVERAGE (If you checked "No" in Step 3 for any person)				
Employee	<input type="checkbox"/> Medicare*	<input type="checkbox"/> Medicaid*	<input type="checkbox"/> Other Health Coverage – Please tell us the plan name	<input type="checkbox"/> Other Reason – Please explain
Spouse	<input type="checkbox"/> Medicare*	<input type="checkbox"/> Medicaid*	<input type="checkbox"/> Other Health Coverage – Please tell us the plan name	<input type="checkbox"/> Other Reason – Please explain
Children	<input type="checkbox"/> Medicare*	<input type="checkbox"/> Medicaid*	<input type="checkbox"/> Other Health Coverage – Please tell us the plan name	<input type="checkbox"/> Other Reason – Please explain
* Loss of coverage under Medicare or Medicaid cannot be used as the basis to waive the 6-month waiting period for late enrollees.				

STEP 5: HEALTH STATEMENT – Please complete for only those persons electing coverage. Misstatements & omissions made by you on this form may cause you to lose coverage under your employer's plan.	
You may be asked to call a medical underwriter to answer questions about any health information you are providing and/or missing information on this form. This interview may be recorded for quality assurance.	
DAYTIME PHONE NUMBER () _____ - _____	

1. Within the past 5 years , have you, your spouse, or dependent children been tested, diagnosed, or treated (including the use of medication), been advised to seek treatment, or has any further treatment been recommended for:		
A. Arthritis, Bone, Joint, Spine, Musculoskeletal Disorders, Muscle or Connective Tissue Disorder		<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Bone Marrow or Organ Transplants:		<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Cancer, Tumor or Polyp:		<input type="checkbox"/> Yes <input type="checkbox"/> No
D. Cirrhosis, Hepatitis or other diseases of the Liver:		<input type="checkbox"/> Yes <input type="checkbox"/> No
E. Collagen Disease including Lupus		<input type="checkbox"/> Yes <input type="checkbox"/> No
F. Digestive System Disorder, including Diseases of the Colon, Gallbladder, Pancreas, Stomach, Esophagus or Intestines		<input type="checkbox"/> Yes <input type="checkbox"/> No
G. Diabetes, Thyroid Disorder or Disease of the Endocrine System		<input type="checkbox"/> Yes <input type="checkbox"/> No
H. Drug Abuse, Alcohol Abuse, Fetal Alcohol Syndrome or Psychiatric Disorder		<input type="checkbox"/> Yes <input type="checkbox"/> No
I. Eyes, Ears, Nose, Throat Disorder, or Meningitis		<input type="checkbox"/> Yes <input type="checkbox"/> No
J. Genetic, Growth or Developmental Disorder		<input type="checkbox"/> Yes <input type="checkbox"/> No
K. Heart, Circulatory Disorder, Blood Disorder (including High Blood Pressure) or Edema		<input type="checkbox"/> Yes <input type="checkbox"/> No
L. Immune System Disorder, including AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)		<input type="checkbox"/> Yes <input type="checkbox"/> No
M. Metabolic and Nutritional Disorders (including Hypercholesterolemia)		<input type="checkbox"/> Yes <input type="checkbox"/> No
N. Quadriplegia, Paraplegia, Hemiplegia or Congenital Disorder		<input type="checkbox"/> Yes <input type="checkbox"/> No
O. Neurological Disorder, including Alzheimer's Disease, Brain Disorders, Cerebral Palsy, Epilepsy, Migraines, Parkinson's Disease, Seizures or Multiple Sclerosis		<input type="checkbox"/> Yes <input type="checkbox"/> No
P. Reproductive System Disorder including Infertility Treatment		<input type="checkbox"/> Yes <input type="checkbox"/> No
Q. Respiratory Disorder or Sleep Disorder		<input type="checkbox"/> Yes <input type="checkbox"/> No
R. Rheumatic Fever or Cystic Fibrosis		<input type="checkbox"/> Yes <input type="checkbox"/> No
S. Urologic Disorders or Renal Disorders (including Renal Failure)		<input type="checkbox"/> Yes <input type="checkbox"/> No
T. Vascular Disorders including stroke, CVA (Cerebro Vascular Accident) or TIA (Transient Ischemic Attack)		<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you, your spouse, or dependent children have any condition that may require diagnostic testing, medical appliances, medical, surgical, or hospital care, or any condition, illness, or injury for which a physician has not yet been consulted?		<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you or any of your dependents currently pregnant or in the process of adopting a child? * Due Date: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you or any of your dependents currently disabled or have been disabled within the past 5 years?		<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you or any of your dependents ever been diagnosed with any form of Cancer? Type: _____ Date Diagnosed: _____ Prognosis: _____ Remission: No Yes, when: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you or any of your dependents been seen in the Emergency Room or any reason within the past 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you or any of your dependents ever had any of the following? (Check all that apply below): Dates _____ <input type="checkbox"/> Heart Attack <input type="checkbox"/> Stents # _____ <input type="checkbox"/> Blood Clots <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> TIA <input type="checkbox"/> Angina <input type="checkbox"/> Pacemaker <input type="checkbox"/> Heart Defect <input type="checkbox"/> Atherosclerosis <input type="checkbox"/> Endocarditis <input type="checkbox"/> Pericarditis <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Aneurysm		<input type="checkbox"/> Yes <input type="checkbox"/> No

STEP 5: HEALTH STATEMENT – Continued

List All Prescribed Medication Taken and Condition(s) being treated for:

Employee
Name of Drug / Dosage / Condition Treated

Spouse

Name of Drug / Dosage / Condition Treated

Child(ren)

Child Name / Name of Drug / Dosage / Condition Treated

Please list the following information:

Most Recent Blood Pressure Reading Most Recent Total Cholesterol Level Family History of Cancer Family History of Heart Disease

Employee: Within Normal Range **<250 / >250** **Yes / No Type:** **Yes / No Type:**
 Outside of Normal Range
 List: _____/_____

Spouse: Within Normal Range **<250 / >250** **Yes No Type:** **Yes / No Type:**
 Outside of Normal Range
 List: _____/_____

* **If Currently Pregnant**, Please list: Due Date: _____ Number of Past Pregnancies (including this one): _____ Number of Live Births: _____

Describe any Known Current or Past Pregnancy Complications below:

For any "Yes" answer given on the previous page to questions under Step 5, please fully complete the following information (Please complete on back of form if more space is needed under Additional Medical Information/Notes)

Question Number & Letter	Person's First & Last Name	Diagnosis <u>AND</u> Date Diagnosed	Treatments <u>Received/ Required OR Recommended</u>	Surgeries <u>Received/ Required OR Recommended</u>	Doctor's Name Phone Number

STEP 6: NOTICES, REPRESENTATION & AUTHORIZATION – Please read this section carefully then sign & date the form below

SPECIAL ENROLLMENT NOTICE

If you decline medical and/or dental coverage for yourself, your spouse, or your dependents at this time for any reason, you may later be eligible to enroll yourself, your spouse and/or your newly acquired dependent(s) in medical and/or dental coverage within 30 days of acquiring the dependent(s) through marriage, birth, adoption, or placement for adoption.

If you decline medical and/or dental coverage for yourself or your dependents at this time because of coverage under other health insurance or group health plan coverage, you or your dependents may later be eligible to apply for medical and/or dental coverage without penalty within 30 days after you or your dependents' other health coverage ends (or after the employer stops contributing toward the other coverage), **but only if you state in STEP 4 that other health coverage is the reason for declining coverage.** The penalty for failure to state that other health coverage was the reason for declining this coverage will be a 6-month waiting period under this plan after you apply for coverage hereunder.

PRE-EXISTING CONDITION LIMITATIONS NOTICE

Alternative Method Election: The **PRE-EXISTING CONDITION** exclusion, if any, applicable to medical, vision, and dental benefits will only be reduced by the number of days you were covered for these benefits under your prior creditable coverage.

If you have a condition (whether physical or mental) for which medical advice, diagnosis, care or treatment was recommended or received within six months of your enrollment date, you will be subject to a pre-existing condition exclusion. A pre-existing condition exclusion is the amount of time when care related to that condition will not be covered. The exclusion period will be measured from the date of enrollment and will be a period of: (a) 12 months for timely entrants (individuals who enroll when first eligible); or (b) 18 months for late entrants. The pre-existing condition exclusion will not apply to: (a) newborns or children under the age of 18 who are adopted or placed for adoption if coverage is requested within 30 days of birth, adoption, or placement for adoption; or (b) pregnancy.

The pre-existing exclusion period may be reduced by the number of days you were covered under a prior health plan or were in a waiting period. You have the right to demonstrate coverage under a prior health plan. To do this, you may request a certificate of coverage from a prior health plan or insurer. Your current plan administrator or American Trust Administrators, Inc. will assist you in obtaining a certificate, if necessary. Following our receipt of a certificate of coverage, you will receive a notice stating the length of your pre-existing condition exclusion period, if any.

ADDITIONAL INFORMATION

To request special enrollment or to obtain more information about it, the preexisting condition exclusion, or creditable coverage, contact the Customer Service Supervisor at American Trust Administrators, Inc. at 800- 843-4121. Attach copies of all certificates of prior coverage from your current plan administrator.

I represent: (1) I am an employee of the participating employer and the persons for whom I am requesting coverage are US Citizens or Legal Aliens residing in the USA; (2) the statements and answers to the questions on this Enrollment/Refusal Form made by me are true and complete to the best of my knowledge; (3) I understand that the statements and answers to questions on this Enrollment/Refusal Form made by me and any subsequent information I provide are the basis for my coverage under my employer's plan and coverage will not be effective until I am notified of my effective date; (4) if any controversy or claim is made arising out of or relating to a claim for benefits payable by the self-funded plan it shall be settled by arbitration in accordance with the provisions of the plan.

I authorize: (1) any physician, medical practitioner, hospital, clinic, pharmacy benefit managers, Veteran's Administration, or other medical-related facility, insurance agent, administrator, insurance company, reinsurer, consumer reporting agency, telephone interview company, or my employer to release any information pertaining to my employment or to the health of myself or my dependents, including physical or mental disorders or the use of drugs and alcohol, to American Trust Administrators, Inc.; (2) American Trust Administrators, Inc. to release such information to any insurance agent, insurance company, reinsurer, managed care organization, telephone interview company, other insurance support organization, or my employer; (3) my employer to deduct contributions from my earnings to be applied to the cost of this plan; and (4) that benefits under this plan be paid directly to any managed care provider utilized by me or my family.

I agree this authorization will be valid for two years from the date this form is signed and that a photocopy of this authorization is as valid as the original for my dependents and myself.

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 crime.

Additional Medical Information/Notes:

HAS ANY PERSON ASSISTED YOU IN THE COMPLETION OF THIS FORM? YES NO

IF YES, PLEASE PRINT NAME: _____

Employee Signature **X** _____
(PLEASE DO NOT PRINT)

Date Signed ____/____/____