



Employee Enrollment / Refusal Form
For groups with 10 OR MORE EMPLOYEES electing medical coverage

INSTRUCTIONS FOR COMPLETING THIS FORM

Misstatements and omissions made by you on this form may cause you to lose coverage under your employer's plan. This form must be completed by the **EMPLOYEE ONLY**. Please Print in ink and **INITIAL & DATE** all corrections. You must be a US Citizen or Alien legally residing and working 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 - -		Birth Date / /		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)	Tobacco User? (Y/N) (Type/Yrs Used)			
Home Phone ()	Work Phone ()	What Company Do You Work For?			
Job Title:	Date Employed Full-Time / /	Your Work Address:			
Hours Worked Per Week:	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) / /	
Personal Email Address:		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 INDIVIDUALS WHO ARE ELECTING COVERAGE							
Only your opposite-sexed spouse, natural children, adopted children, and step-children, are eligible to enroll. If the spouse's last name is different than the employee, please provide a copy of the marriage certificate with this enrollment form.							
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
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 enrollment form live with you at the address shown above?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "No", please write their name(s) and full home address if different from yours:							

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:			
Home Office Use Only:						
Plan:	Location:	EE Coverage Code:	SP Coverage Code:	CH Coverage Code:	Date Signed:	
Prior Coverage:						

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 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

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**, based upon other than the results of genetic testing, have you, your spouse, or dependent children been tested, treated **(including the use of prescription medication)**, been advised to seek treatment, or has any further treatment been recommended for; or diagnosed based on manifested symptoms other than genetic tests as having:

A. Arthritis, Bone, Joint, Spine, Muscle or Connective Tissue Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Bone Marrow or any Organ Transplant or replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Urologic Disorders or any Disorder of the Kidney; or Cirrhosis, Hepatitis or other diseases of the Liver	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. Digestive System Disorder, including Diseases of the Colon, Gallbladder, Pancreas, Stomach, Esophagus or Intestines	<input type="checkbox"/> Yes <input type="checkbox"/> No
E. Diabetes, Thyroid Disorder or Disease of the Endocrine System	<input type="checkbox"/> Yes <input type="checkbox"/> No
F. Drug Abuse, Alcohol Abuse, Fetal Alcohol Syndrome or Psychiatric Disorder including ADD & ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No
G. Eye, Ear, Nose, and/or Throat Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
H. Genetic, Growth or Developmental Disorder (do not disclose genetic disorders that have not manifested to the point that they could be diagnosed by a physician based upon the presence of physical symptoms).	<input type="checkbox"/> Yes <input type="checkbox"/> No
I. Rheumatic Heart Disease, Heart Disorder, Circulatory Disorder, Blood Disorder (including High Blood Pressure) or Edema Ever had a Heart Attack: Yes:# of times: _____ List Date(s): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
J. Lupus or other autoimmune disorder or disease; an Immune System Disorder, including disorder of the Spleen, AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)	<input type="checkbox"/> Yes <input type="checkbox"/> No
K. Metabolic and Nutritional Disorders (including high cholesterol)	<input type="checkbox"/> Yes <input type="checkbox"/> No
L. Quadriplegia, Paraplegia, Hemiplegia or Congenital Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
M. Neurological Disorder, including Alzheimer's Disease, Brain Disorders, Cerebral Palsy, Epilepsy, Migraines, Parkinson's Disease, Seizures, Multiple Sclerosis, or Meningitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
N. Reproductive System Disorder including Infertility Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
O. Respiratory Disorder, Cystic Fibrosis or Sleep Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
P. Have you ever had a child born prematurely?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Q. Are you or any of your dependents currently pregnant or has anyone to be covered ever had any complications of pregnancy, or are you or any of your dependents currently in the process of adopting a child? Due Date or expected date of adoption: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
R. Vascular Disorders including stroke, CVA (Cerebrovascular 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 (other than genetic disorders that have not physically manifested) 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 disabled or have been disabled within the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you or any of your dependents ever been diagnosed with any form of Cancer? Type: _____ Date Diagnosed: _____ Prognosis: _____ Remission: <input type="checkbox"/> Yes <input type="checkbox"/> No, when: _____ Cancer Stage: _____ Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No, Radiation <input type="checkbox"/> Yes <input type="checkbox"/> No Last date of chemo or radiation _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. 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
6. Most recent blood pressure reading: Employee _____ <input type="checkbox"/> Unknown Spouse _____ <input type="checkbox"/> Unknown	
7. Most recent cholesterol level: Employee _____ <input type="checkbox"/> Unknown Spouse _____ <input type="checkbox"/> Unknown	

8. **List All Prescribed Medication Taken and Condition(s) for which the drug was prescribe (attach a signed, separate sheet if needed):**

<u>Employee</u>	<u>Spouse</u>	<u>Child(ren)</u>
<u>Name of Drug / Dosage / Condition Treated</u>	<u>Name of Drug / Dosage / Condition Treated</u>	<u>Child Name / Name of Drug / Dosage / Condition Treated</u>

9. Please advise if any person for whom you have requested coverage is: (a) on Medicare; and/or (b) had a Kidney transplant or had Renal Dialysis. If Yes to (a) and/or (b), provide the person's name and applicable HIC# _____

