EMPLOYER PLAN

Employee Enrollment Form

Please check one.

Requesting coverage as an employee/dependent for an Employer Plan.

Requesting coverage as an employee/dependent to be added to an existing Employer Plan. Case #________________________

Requesting to decline coverage.

Failure to complete this form in its entirety could result in a delay.

A. EMPLOYEE/DEPENDENT INFORMATION (All eligible employees must complete Section A.)

LAST NAME (IF DIFFERENT) FIRST MI	SEX	HEIGHT	WEIGHT	RELATIONSHIP	DATE OF BIRTH	FULL-TIME STUDENT
	M F			EMPLOYEE		N/A
	M F			SPOUSE CHILD		YES NO
	M F			CHILD		YES NO
	M F			CHILD		YES NO
	M F			CHILD		YES NO

B. EMPLOYEE INFORMATION (All eligible employees must complete Section B.)

HOME ADDRESS	HOME PHONE NUMBER	BEST TIME FOR US TO CALL AM PM
CITY/STATE/ZIP	WORK PHONE NUMBER	BEST TIME FOR US TO CALL AM PM
COUNTY	MOBILE NUMBER	E-MAIL ADDRESS
SOCIAL SECURITY NUMBER	MARITAL STATUS SINGLE MARRIED	JOB TITLE OR OCCUPATION
EMPLOYER	DATE OF FULL-TIME EMPLOYMENT	
TRUST / ASSOCIATION NAME:		
Are you a/an (leave blank if not applicable) OWNER PARTNER CORPORATE OFFICER	MONTHLY EARNINGS	WEEKLY HOURS WORKED

ADMINISTRATIVE USE ONLY	TIMELY EE	SPEC ENROLL	LATE ENROLL	24-HR CVG Yes No	LIFE AMOUNT	PCEFDT	PRE-EX ENDS	EFF DATE	UW APPRV	PART #	ENTERED BY

EMPLOYEE ENROLLMENT FORM

→ ***If applying for coverage GO TO SECTION D.***
If requesting to decline coverage for yourself and/or your eligible dependent(s), COMPLETE ALL OF SECTION C AND SIGN.

C. REQUEST TO DECLINE COVERAGE

1. I, or my dependents, decline coverage because of the following:

EMPLOYEE	SPOUSE	CHILD(REN)	**MEDICAL**
			a) Have coverage under another health plan.
			b) Choose not to have health plan coverage currently.
			DENTAL
			a) Have coverage under another group dental plan.
			b) Choose not to have dental coverage currently.
			VISION
			a) Have coverage under another group vision plan.
			b) Choose not to have vision coverage currently.

If declining offer of coverage due to other coverage, please list name and phone number of insurance company (or employer if self-funded plan and policy number.)

	INSURANCE COMPANY NAME IF KNOWN **OR** EMPLOYER IF SELF-FUNDED	PHONE NUMBER	PRIMARY INSURED & SSN	POLICY NUMBER (IF KNOWN)
Employee Spouse Child				
Employee Spouse Child				
Employee Spouse Child				

This is to acknowledge I have been given the opportunity to apply for the available coverages and have elected not to enroll myself or my dependents, if any. I understand that by applying for coverage at a later date I may be considered a Late Applicant. If I am a Late Applicant, I will be subject to a 9-month deferral of coverage period followed by a 9-month pre-Existing exclusion limitation period. I represent I have not been persuaded to waive coverage by anyone.

I understand that if I waive coverage for myself or my dependents because of being covered under other health Insurance coverage, I may, in the future, be able to enroll myself or my dependents in this plan if the other health coverage terminates.

The other health coverages must have terminated because of either: 1) the "loss of eligibility" for coverage, or 2) the termination of Employer Plan by the employer. I understand I must apply for coverage within 30 days after my other coverage ends to be eligible for this special exception. "Loss of eligibility" includes a loss of coverage due to legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment. Loss of eligibility does not include an individual's failure to pay contributions on a timely basis or by the termination of coverage for cause. Examples of a loss of coverage for cause include the making of a fraudulent claim or an initial misrepresentation of fact in connection with a group health plan. In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I understand I may be able to enroll myself or my dependents, provided that I apply within 30 days after the marriage, birth, adoption or placement for adoption.

Signature of Employee (if declining coverage) **DATE**

ALL APPLICANTS WAIVING COVERAGE MUST SIGN AND DATE SECTION C.

D. COVERAGE REQUESTED

All benefits listed below may not be available. Please check with your Employer for availability of benefit options to you and your dependents.
I am applying for:

Employee Basic Life/AD&D Insurance only (I have completed the Waiver Section of this Enrollment Form declining Medical/Dental/Vision Coverages, if applicable,) (Complete all sections of the Enrollment Form also)

Basic Life/AD&D Coverage (If your Employer elected this benefit, this benefit automatically applies to you).

Basic Dependent Life Coverage (If your Employer elected this benefit, this benefit automatically applies to you).

Short Term Disability (STD) (If your Employer is paying 100% of the cost, this benefit automatically applies to you.)

Long Term Disability (LTD) (If your Employer is paying 100% of the cost, this benefit automatically applies to you).

Voluntary Employee Life **Voluntary Short Term Disability (STD)**

Voluntary Dependent Life **Voluntary Long Term Disability (LTD)**

Medical Coverage:
Employee Only Employee & Spouse Employee & Child(ren) Employee, Spouse & Child(ren)

Dental Coverage:
Employee Only Employee & Spouse Employee & Child(ren) Employee, Spouse & Child(ren)

Vision Coverage
Employee Only Employee & Spouse Employee & Child(ren) Employee, Spouse & Child(ren)

Employee Medical Choice – If your employer offers employee choice, please list your Medical Plan selection below:
Refer to your Employer for your available Plan options. Plan #______ Option# _______

Does any of your dependents applying for coverage under this plan have other Medical, Dental or Vision Coverage?
Yes NO If yes, what type of coverage" Medical Dental Vision What family members have the other coverage?

E. LIFE INSURANCE

BENEFICIARY	RELATIONSHIP

F. PROVIDER NETWORK

PROVIDER NETWORK: ____.

G. PRIOR INSURANCE COVERAGES INFORMATION

1. Has anyone applying, been covered through any other plan of health insurance within the past 63 days?

NO (Go to Section H)
YES 1) Attach a copy of the certification of group health insurance plan coverage or other documentation of creditable coverage.
2) Please complete the following:

NAME & PHONE NUMBER OF HEALTH INSURANCE COMPANY		NAME & SOCIAL SECURITY NUMBER OF PRIMARY INSURED	
PLAN NUMBER	TYPE OF COVERAGE	EFFECTIVE DATE	TERMINATION DATE
	INDIVIDUAL EMPLOYER GROUP		

If applying for dental insurance, employees who are covered under their Employer's dental and or Vision plan on the date immediately prior to the effective date of coverage on this Plan will be given credit for the satisfaction of any calendar year deductible amounts and waiting periods under this new Plan.

H. HEALTH QUESTIONS

Please provide complete details to any question marked "Yes" in the appropriate space provided in Section I. We may need to request additional information regarding your health history from you and/or your attending physician.

A. Yes No Are you or any enrolling dependents receiving treatment or been advised of a condition that will require medical attention or to have medical test(s)? If yes, list names and explain in Section I.

B. Yes No Are you or any enrolling dependents currently disabled, confined to a hospital, medical facility or the home? If yes, list names and explain in Section I.

C. Yes No Have you or any applying dependents incurred medical expenses over $10,000 in the last 12 months? Please provide a list of names and explain in Section I.

D1. Yes No Are you or your enrolling dependents currently taking or have been prescribed medications within the past 12 months? If yes, please fill in the appropriate information.

D2. MEDICATIONS CURRENTLY PRESCRIBED OR BEING USED (List details/medication below.)

Person's Name	Medication	Frequency and Dosage	Length of time on medication?	Complete Names and Addresses of Physicians

E. Within the past five years, has any person to be insured had any symptoms, diagnosis, consultation, treatment, or taken any medication or received counseling for:

E1. CIRCULATORY SYSTEM:	a) Yes No	Abnormal Heart Beat/Palpitations, Blood Disorder/ Hemophilia/ Hypertension, Chest Pain, Heart Disease/ Murmur/ Heart Attack or Coronary Artery Disease, Lymphadenopathy/Immune Disorder, Stroke, Vascular Disorder
	b) Yes No	High Blood Pressure (Current Readings ______/_______), (______/______) High Cholesterol (Current Reading __________) High Triglycerides (Current Reading _________)
E2. CYST/POLYP/TUMOR:	Yes No	Cancer, Tumors/ Cysts/ Polyps/ Growths
E3. ENDOCRINE DISORDERS:	Yes No	Diabetes/ Pancreatic Disorders, Thyroid or Goiter
E4. GASTROINTESTINAL DISORDERS:	Yes No	Colitis, Hepatic, Spastic Colon, Polyps, Digestive Disorder/ Reflux, Gallbladder Disorder, Hernia, Ulcerative Colitis/Crohn's/ Regional Ileitis, Ulcers, Hepatitis (A, B or C), Liver Disorder
E5. GENITO URINARY DISORDERS:	a) Yes No	Abnormal Pap Smear, Bladder Disorder, Breast Disorder, Infertility Testing/Treatment, Kidney Disorder, Menstrual Disorder, Prostate/Rectal Disorder, Reproductive Organs Disorder/ Endometriosis, Sexually Transmitted Diseases
	b) Yes No	Current Pregnancy (Expected Due Date ___________)
E6. NERVOUS DISORDERS:	Yes No	Anorexia/Bulimia, Epilepsy and/or Seizure, Headaches/ Migraines, Mental, Nervous, Emotional Disorder/Anxiety/ Depression/ Attention Deficit Disorder, Mental Retardation/Down's Syndrome, Muscular Dystrophy/ Cerebral Palsy, Neurological Disease, Paralysis, Sleep Disorders
E7. OTHER DISORDERS:	Yes No	Abnormal Test Results, Alcoholism/Alcohol Abuse, Drug Addiction, Ear/Throat Disorders, Eye Disorders, Acquired Immune Deficiency Syndrome (AIDS), Transplants
E8. RESPIRATORY DISORDERS:	Yes No	Allergies, Asthma/ Respiratory Disorder, Cystic Fibrosis, Emphysema/ Lung Disorder, Sinus Disorder, Tuberculosis
E9. SKELETAL/ MUSCULAR DISORDERS:	Yes No	Arthritis, Back/Muscle/Joint Disorder, Bone Disease/Deformity, Congenital Disorder Fractures/ Dislocations, Lupus/Systemic or Discoid, Rheumatism, Skin Disorder, Spinal Disorder/ Back/ Neck Strain

I. HEALTH HISTORY

INSTRUCTIONS: Please complete the *HEALTH HISTORY SECTION* for any "yes" responses in Section H.

Ques. No.	Person's Name	Condition(s) and Treatment	Date of Onset Mo./Yr.	Recovery Date Mo./Yr.	Complete Names and Addresses of Physicians & Hospitals

Any person who, with intent to defraud or knowing that he/she is facilitating a fraudulent act against an insurer, or submits an application or files a claim containing a false or deceptive statement, may commit a fraudulent insurance act, which is a crime and subjects the person to civil and criminal penalties.

J. YOUR ACKNOWLEDGEMENTS

CONTRIBUTIONS: I authorize my employer to deduct the required contributions, if any, from my earnings.
FULL-TIME EMPLOYMENT: I understand that one of the requirements for eligibility on the effective date and for continued eligibility under the plan is that I am actively at work and employed full-time (at least thirty [30] hours per week) at my employer's place of business.
PRE-CERTIFICATION: I understand that failure to pre-certify treatment may results in reduced benefits pursuant to the terms of the Plan.
BENEFIT AVAILABILITY: I understand that my benefits under this plan begin with a specific effective date of coverage applicable to me and coverage ends at the end of a month in which due contributions have not been paid. I understand if I attempt to utilize the Employer Plan or prescription drug card when coverage is no longer effective under the plan, I will be personally responsible for those expenses incurred and can be billed by the providers or thr Trust for these services.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any physician or medical practitioner, hospital, or other organization, institution or person that has any medical information or knowledge of me or my family as to diagnosis, treatment and prognosis regarding any physical, mental, drug or alcohol condition or any and all such information to be given to the authorized Administrator or legal representative. Any information obtained will not be released by the Company except to persons or organizations performing business or legal services in connection with my Enrollment Form or claim, including but not limited to Pre-certification of hospital admissions, Continued Stay Review, On-Site Concurrent Review or as may be otherwise lawfully required or as I further authorize. (Photocopy of this authorization shall be valid as the original and is valid for thirty [30] months from the date shown below.)
U.S. RESIDENT: I understand that the coverage under this plan is available for United States residents and benefits are not payable for medical expenses outside of the United States except when traveling.
MY ANSWERS ARE TRUE AND CORRECT: I have personally reviewed all of my answers to the questions on this Enrollment Form and represent that all of the information I have provided is true and complete. I understand that it is my responsibility to provide truthful, complete and accurate information and I represent I have fully understood all questions asked. I understand that any intentional ma-terial misstatements or failure to report information may be used as the basis of rescission or termination of coverage for me or my de-pendents. I understand that under no circumstances is anyone allowed to (a) waive, alter or modify any questions; (b) permit me to inac-curately answer any questions; or (c) instruct me not to disclose any particular medical condition on the Enrollment Form. I understand that no one is authorized or has authority to alter the terms of the Employer's Plan.
EMPLOYEE ENROLLMENT FORM: I understand that my employer adopted and agreed to participate in the Plan. I understand that my coverage will not be in force until this enrollment form is approved by the authorized Administrator in accordance with the underwriting guidelines in effect.

K. SIGNATURE

	Signature of Employee (and parent if applicant is under age 18)		DATE	

BEFORE YOU RETURN THE ENROLLMENT FORM – SOME *IMPORTANT* ITEMS!

Section A…Dependent Information - A child age 26 and under is only eligible if the child is unmarried and maintains a "Full-time" student status. "Full-time" means currently enrolled and attends an accredited college or university for 12 credit hours per semester. The child should still be dependent upon you for support.

Section E…Beneficiary - If life insurance coverage is included as an employer benefit, it is in your best interest to designate a personal beneficiary. Only if no beneficiary exists, should you indicate "Estate" in this section.

Section H, I… Please provide complete details. Additional information about your medical history may be requested regarding your health history from you and/or your attending physician.

PLEASE COMPLETE AND SIGN THE ENROLLMENT FORM WHETHER YOU APPLY FOR OR ARE DECLINING COVERAGE!!