



EMPLOYEE SELF-FUNDED HEALTH PLAN ENROLLMENT CARD

May be Photocopied or Duplicated for use. Please complete in ink and initial any alterations.



SECTION 1 – EMPLOYEE INFORMATION

FULL NAME OF EMPLOYEE				MARITAL STATUS		ADM. USE ONLY	
RESIDENCE ADDRESS		CITY	STATE	ZIP		CASE NO.	
TELEPHONE NUMBER (include area code)		Best time to contact (if additional information is required by administrator)				EMPLOYEE NO.	
DATE BEGAN FULL TIME (mm/dd/yy)			SOCIAL SECURITY NUMBER			CLASS	
EMPLOYED BY		EMPLOYER'S PHONE (include area code)		AVG. NO. HOURS WORKED WEEKLY		EFFECTIVE DATE	
EMPLOYER'S LOCATION – STREET ADDRESS			CITY	STATE	ZIP	OCC YES <input type="checkbox"/> NO <input type="checkbox"/>	
OCCUPATION AND DUTIES						UWF 48 YES <input type="checkbox"/> NO <input type="checkbox"/> DATE _____	
<input type="checkbox"/> I AM <input type="checkbox"/> I AM NOT AN OWNER, PARTNER OR CORPORATE OFFICER						UWF 40 YES <input type="checkbox"/> NO <input type="checkbox"/>	
I Am Enrolling for (check one): <input type="checkbox"/> SELF ONLY <input type="checkbox"/> SELF AND SPOUSE <input type="checkbox"/> SELF AND CHILD(REN) <input type="checkbox"/> SELF, SPOUSE & CHILD(REN)						HEALTH YES <input type="checkbox"/> NO <input type="checkbox"/>	

DEPENDENT WAIVER

If you have dependents (spouse and/or children) and are not enrolling **all** of them, please complete the following:

I AM NOT ENROLLING MY (check one or both): SPOUSE CHILD(REN) (check one)
BECAUSE: Covered by another group/individual health plan. Other (explain) _____

I understand I have the right to enroll my dependents at this time. I am voluntarily declining to enroll my dependents and have not been induced or pressured by anyone to decline such coverage. I understand that, if I do not enroll my dependents at this time, and they do not have other qualifying coverage, their right to enroll in the future may be restricted, with a delayed effective date or an extended Pre-Existing Condition Limitation Period.

PARTICIPANT INFORMATION Complete for each person to be enrolled (use additional sheet if necessary).							ADM. USE ONLY				
NAMES OF PARTICIPANTS	RELATIONSHIP	SEX	HEIGHT	WEIGHT	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MUW	MHX	LAT	D&R	PXT
1. Employee Name	Self										
2.											
3.											
4.											
5.											

SECTION 2 – PRIOR COVERAGE CREDIT

Have you or your dependents been covered under any health benefit plan within the last 90 days? YES NO

If Yes, to establish prior coverage credit, please provide the following information on all coverage in force in the past 12 months (most of this information can be obtained from your current benefit plan Identification Card):

Coverage Type Comprehensive Major Medical Other (please provide copy of the benefit plan or schedule of benefits)

Name of Health Plan _____ Health Plan Phone Number (_____) _____

Effective Date of Prior Coverage _____ Termination Date _____

Reason for Coverage Termination _____

Plan Type Employer Sponsored Employer Name _____ Policy/Cert. Number _____

Individual Policy/Certificate Number _____

Coverage was for (check all that apply): Self Spouse Children

Proof of coverage is required if prior coverage is other than your current employer's plan. Please provide us with a copy of your Certificate of Creditable Coverage provided by the health plan or other suitable documentation. If coverage for self or a dependent is from a different source please document on a separate sheet of paper and attach.

Complete information on all pages in ink. Sign and date last page.

SECTION 3 – MEDICAL INFORMATION

Please provide details for any “Yes” answer below

1. In the past 5 years, have you or anyone enrolling for coverage had a diagnosis of or consultation, treatment or medication for:
- | | <u>YES</u> | <u>NO</u> | | <u>YES</u> | <u>NO</u> |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| Brain or Nervous System | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes or Sugar in Urine | <input type="checkbox"/> | <input type="checkbox"/> |
| Endocrine or Adrenal Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Digestive or Gastrointestinal Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| Liver, Pancreas or Kidney | <input type="checkbox"/> | <input type="checkbox"/> | Breast or Reproductive Organs | <input type="checkbox"/> | <input type="checkbox"/> |
| Abnormal Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune Disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart or Circulatory System | <input type="checkbox"/> | <input type="checkbox"/> | Disorders of Back or Spine | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest Pain or Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema, Tuberculosis, Chronic | | |
| Lymphatic Vessels or Glands..... | <input type="checkbox"/> | <input type="checkbox"/> | Obstructive Pulmonary Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Cirrhosis or Hepatitis..... | <input type="checkbox"/> | <input type="checkbox"/> | Multiple Sclerosis or Cystic Fibrosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia or Hodgkin’s Disease..... | <input type="checkbox"/> | <input type="checkbox"/> | Skin or Collagen Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer (excluding Basal Cell Carcinoma)..... | <input type="checkbox"/> | <input type="checkbox"/> | Disease of the Muscles | <input type="checkbox"/> | <input type="checkbox"/> |
2. Within the last 5 years, has anyone enrolling for coverage been diagnosed as having or been treated for human immunodeficiency virus (HIV) infection, any other acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC) condition, significant weight loss, chronic fatigue, diarrhea, night sweats or enlarged glands? YES NO
3. Are you or any dependent (whether enrolling for coverage or not) currently pregnant or anticipating surgery, or is anyone enrolling for coverage disabled, restricted or unable to perform the normal activities of daily living and self care?..... YES NO
4. During the past 5 years, has anyone enrolling for coverage visited a doctor, had a medical consultation, had surgery, or been hospitalized? YES NO
5. Are you or any dependent enrolling for coverage currently taking medication? YES NO
6. For anyone enrolling for coverage, is there any existing medical condition or problem (including any undiagnosed symptoms) that has not otherwise been disclosed on this enrollment form? If “yes” answer, provide details below. YES NO

Use this space to give details to any “YES” answer to questions 1 through 6. Use a separate sheet if additional space is needed; sign & attach additional pages. If taking medication for high blood pressure, please include your last 3 blood pressure readings.

Person	Medical Condition or Specific Reason for Treatment	Dates of Treatment	Medications & Dosages	Recovery Status	Please list any treatment, surgery or anticipated surgery for this condition.

Complete information on all pages in ink. Sign and date last page.

SECTION 4 – EMPLOYEE STATEMENT AND SIGNATURE

I HEREBY: Request enrollment in the self-funded Group Health Plan (Plan) established and maintained by my employer (Employer) for its eligible employees and their eligible dependents; Represent that I am an eligible employee of the Employer; Represent that my statements and answers to the questions in this enrollment form are true and complete to the best of my knowledge and belief; and Authorize the Employer to deduct any required Plan contribution from my earnings.

I FURTHER ACKNOWLEDGE AND UNDERSTAND: This is not an insured benefit plan; All Plan benefits are self-funded (self-insured) by the Employer; The Employer is solely responsible for all benefit payments; Coverage is not effective until the Plan approves this enrollment form; Plan benefits are available only if a person is covered under, and all required contributions for such coverage have been received by, the Plan; If I have waived coverage for a dependent, I also waive all claims under the Plan for benefits for that dependent, and if I decide to enroll that person at a later date, the effective date for my dependent may be delayed, or an 18-month Pre-Existing Condition Limitation Period may apply; A full description of the medical expense benefits under the Plan appears in the Summary Plan Description, which summarizes the official Plan Document; The agent submitting this enrollment lacks authority to change the enrollment form, approve Plan coverage, alter Plan terms, or adjust claims; The Employer has delegated certain non-fiduciary, ministerial administrative acts, duties and responsibilities of the Plan to Allied National, Inc., a licensed third-party administrator (Allied); However, the Sponsoring Employer remains the Plan Sponsor, Plan Fiduciary, Plan Administrator and Plan Trustee and is responsible for all coverage determinations and benefit payments; Allied does not insure the Plan and is not responsible for funding benefit payments; My statements and answers in this enrollment form will be the basis for approving Plan coverage and any material misrepresentation or omission may result in an increase in Plan contribution rates or termination of my coverage; Any person who, knowingly and with intent to defraud, submits an enrollment form, or files a claim, containing a materially false statement, or omitting materially false information, may be found guilty of fraud in a court of law.

THIS PLAN CONTAINS A PRE-EXISTING CONDITIONS LIMITATION: If you (or your dependent) have a medical condition before enrolling in the Plan, you (or your dependent) may be subject to a 12-month pre-existing condition limitation period (18 months for late enrollees), unless reduced or eliminated by Creditable Coverage; This exclusion applies only to medical conditions for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) month period prior to your effective date of coverage under the Plan (or the start of any waiting period); This exclusion does not apply to pregnancy, anyone under 19 years of age, or dependent children enrolled in the Plan within 30 days of birth, adoption or placement for adoption; Prior health coverage for you (or your dependent) may be used to reduce or eliminate the pre-existing condition limitation, but only if it qualifies as Creditable Coverage and you have not experienced a break in coverage exceeding sixty-two (62) consecutive days; You (or your dependent) have the right to document proof of Creditable Coverage, by requesting a "Certificate of Creditable Coverage" (or other proof of coverage) from your prior plan and submitting to Allied; You may also demonstrate Creditable Coverage by other means; Contact Allied Customer Service at 800-825-7531 for assistance.

SPECIAL ENROLLMENT RIGHTS: If you acquire a new dependent by marriage, birth, adoption or placement for adoption, he/she may be able to enroll without delay or penalty, if you request enrollment within 31 days (of the marriage, birth, adoption or placement for adoption); If you decline enrollment for any dependent (including your spouse) because of other health plan or group insurance coverage, and that dependent subsequently becomes ineligible for the other coverage (or the employer stops contributing towards that coverage), he/she may be able to enroll without delay or penalty, if you request enrollment within 31 days of ineligibility or termination of employer contributions; If you decline enrollment for any dependent (including your spouse) because of coverage under Medicaid or a State child health plan, and that dependent's coverage is subsequently terminated due to ineligibility, he/she may be able to enroll without delay or penalty, if you request enrollment within 60 days of the termination of coverage; If you decline enrollment for any dependent (including your spouse) and that dependent subsequently becomes eligible for a premium assistance subsidy from Medicaid or a State child health plan, he/she may be able to enroll without delay or penalty, if you request enrollment within 60 days of eligibility for the subsidy. To request special enrollment contact the Employer or Allied Customer Service at 800-825-7531.

PERSONAL INFORMATION NOTICE: As required by law, this notice is intended to inform you that 1) Personal information may be collected from third parties; 2) Such information as well as other personal or privileged information collected by the health plan or its legal representative may be in certain instances, as prescribed by law, disclosed to other third parties without your prior authorization; 3) You have the right to access and correct the collected information; 4) Your right to access does not include any information which relates to and is collected in connection with, or in reasonable anticipation of, a claim or civil or criminal proceeding; 5) We will provide a more detailed notice of information practices upon request.

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize the disclosure of all nonpublic personal information and individually identifiable protected health information for me (and my dependent(s), if applicable), including but not limited to employment status, other health plan coverage, diagnosis, prognosis, medical treatment or care, and physical or mental conditions (including alcohol or drug dependency), by any physician, medical practitioner, hospital, other medical related facility, insurance company, employer or benefit plan having such information, to the health plan or its legal representative, agent or vendor, for the purpose of processing enrollment and claims. I acknowledge and agree that this authorization shall be valid for two (2) years; that I may revoke it in writing at any time; that I may request a copy of this authorization; that enrollment, but not the processing of claims, is conditioned on my signing this authorization; that this authorization will be used as its own document, separate from the enrollment form; that a photocopy of this authorization shall be as valid as the original; that any documentation or information disclosed pursuant to this authorization may be re-disclosed and may no longer be covered by federal or state privacy laws; and that I have authority to act as the personal representative of my dependent(s) (if requesting dependent coverage).

Signature of Employee X _____ Date _____