



EMPLOYEE ENROLLMENT FORM Level-Funded Medical Coverage

Employer Name: _____	Employer Location (if more than one) _____
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ENROLLEE INFORMATION				
Last Name:	First Name:	Initial:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> Single Height: _____	
			<input type="checkbox"/> Married Weight: _____	
Address:	City:	State:	Zip:	
County:	Home Phone #:	Enrollee Social Security Number:		
Date of Birth: ____ / ____ / _____	Occupation:	Language Preference:	Annual Salary:	Average Hours Worked Per Week:
Date Employed Full Time: ____ / ____ / _____	Are you an independent contractor? <input type="checkbox"/> Y <input type="checkbox"/> N		\$	

ANCILLARY PLAN OPTIONS (If offered by your employer):

Freedom Dental™

- Fully Insured Freedom Dental™ Plan Selection: \$1,000 \$1,500 \$2,000 \$2,500 Network: PPO or EPO (select one)
 Network Vendor: First Dental Health (Default) or Other: _____
- Pre-Paid DHMO / Western Dental®
- 100% Self-Funded Dental (must complete the Employer Elect Application)

Eagle Vision™

- 100% Self-Funded Vision Plan

WAIVER (Please complete if you are declining medical coverage)

Check all of the following that apply:

- I waive medical coverage for: Employee Spouse Child(ren)
- I waive dental coverage for: Employee Spouse Child(ren)
- I waive vision coverage for: Employee Spouse Child(ren)

Reason for waiving coverage: _____

Qualifying Coverage _____ Other _____

If I have waived coverage for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in the coverage, provided that I request enrollment within 31 days after my other coverage ends because of involuntary loss of other coverage (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll my dependents, provided that I request enrollment within 31 days after the date of the event. I further understand that if I am considered a late enrollee, I may be declined from coverage or excluded from coverage for a period of time as defined in and where permitted by law, and I may be required to provide, where allowed by law, Medical History satisfactory to the Plan Sponsor or Administrator, for myself and/or my dependents.

ELIGIBILITY & OTHER INSURANCE INFORMATION

Currently, are you working full-time? <input type="checkbox"/> Y <input type="checkbox"/> N	Do you or any family members intend to keep other insurance coverage in addition to this coverage? <input type="checkbox"/> Y <input type="checkbox"/> N
If no, explain: _____	If yes, list family members: _____
List the name of the other insurance company(ies) and the policy number(s): _____	List family members covered by Medicare and their effective date: _____

COVERAGE & CHANGE REQUEST INFORMATION

Coverage Level: <input type="checkbox"/> Employee <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren)	Name of medical plan you have selected: _____
Change Request: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Adoption <input type="checkbox"/> Returning to school full-time <input type="checkbox"/> Court Order	PPO Network Name: _____
Date of Event (you may be required to provide proof of the event): ____ / ____ / ____	
**Attach a written and signed statement by the employer for a requested coverage effective date. Effective date may not be guaranteed.	

FAMILY INFORMATION

(Only for those applying for coverage)

First Name & M. I. (last name if different)	Gender	Date of Birth	Height	Weight	Social Security No.	Primary Care Physician's Name
Spouse:	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			/ /	
Child:	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			/ /	
Child:	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			/ /	
Child:	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			/ /	

REQUIRED MEDICAL INFORMATION

- Y N Are you or any dependent disabled, hospital confined, or pregnant? If pregnant, due date: ___/___/___
If pregnant, are you expecting a multiple birth / having complications / planning a C-Section? Y N
- Y N Have you or any eligible dependent used tobacco products in the past twelve (12) months?
- Y N Are you or any eligible dependent receiving treatment; taking medication; receiving follow up care; scheduled for or awaiting results of any tests, biopsies, procedures or lab work; been advised to have a test; or been advised of a condition that will require attention in the next twenty-four (24) months?
- Y N In the past five (5) years, have you or any eligible dependent to be insured had any symptoms, diagnosis, consultation, testing, treatment, follow up care, or taken any medication or received counseling for any of the following:

- | | | | | | | | | | | | |
|---|--------------------------|-----|--------------------------|----|-----------------------------------|---|--------------------------|-----|--------------------------|----|---|
| a | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Diabetes | j | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Mental Disorder Alcohol/Drug Abuse |
| b | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Kidney Disorder | k | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Heart/Blood/Vascular/Hypertension |
| c | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Infertility | l | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Birth Defects/Congenital Disorder |
| d | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Neurological Disorder | m | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Stroke |
| e | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Arthritis/Back/Joint Disorder | n | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Organ/Tissue Transplants |
| f | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Cancer/Tumor | o | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Respiratory/Lung Disorder |
| g | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Liver Disorder/Hepatitis | p | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Immune System Disorder |
| h | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Systemic Lupus/Multiple Sclerosis | q | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Acquired Immune Deficiency Syndrome(AIDS) / |
| i | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Intestinal / Digestive Disorder | | | | | | AIDS Related Complex (ARC)/HIV |

Please provide details to "Yes" answers, including information regarding last doctor visit and/or physical examination and all medications taken (attach extra pages if needed with signature and date.)

Question/Letter	Name	Illness/Impairment	Dates Treated	Medications/Treatment/Surgery/Treating Physician

EMPLOYEE AGREEMENT – SIGNATURE REQUIRED

***To be a valid enrollment, your signature and the date you sign it are required.**

I understand that the previous answers will be relied upon by the Plan Sponsor in the issuance of a Summary Plan Description. I declare all statements contained in this entire form about me and my dependents are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand that my intentional misrepresentation of a material fact or my failure to report information about me or my dependents may be used as the basis to rescind, terminate or modify coverage for me or my dependents. Rescind means that the coverage was never in effect. I understand and agree that the Plan Sponsor is not bound by any statement made by or to any agent unless written herein. I agree that no coverage will be effective until the date specified by the Plan Sponsor in the Summary Plan Description. The actual effective date may not be the requested effective date. If I am now waiving medical benefits for myself and/or my dependents, I have read the entire Waiver provision, and understand the enrollment requirements if I make request for such benefits at a later date. I authorize my employer to deduct the necessary contribution toward the benefits. I reserve the right to revoke this deduction authorization at any time upon my written notice. Benefits are effective only after approval by the Plan Sponsor or Administrator and satisfaction of any probationary period. To assist with determining my creditable coverage, I authorize any insurance company, third party administrator, or other carrier or provider of health benefits to release to the third party administrator and/or Plan Sponsor certificates of creditable coverage and all such information. Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false information may be found guilty of fraud, which is a crime, in a court of law and may be subject to fines and confinement in prison. This will not be considered as a complete application unless all pages are attached and completed.

I understand that information on this application is valid for a maximum of 90 days from the date of signature.

Enrollee Signature X _____ Date (required) _____ If signed by a representative of enrollee, please indicate

the representative's authority to act on behalf of enrollee.

SIGNATURE REQUIRED / AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR ENROLLMENT

I also hereby authorize any physician, medical practitioner, hospital, clinic, Veterans administrations facility, other medical or medically related facility, insurance or reinsurance company, pharmacy, pharmacy benefit manager, health plan, or Consumer Reporting Agency, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and/or treatment of me or my minor children and other non-medical information of me and my minor children, to release to the claims or third party administrator, any other excess loss insurance carrier designated by the Plan, or its legal representative, any and all such information as required for determination of eligibility for benefits. I understand that I may request a copy of this authorization at any time. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I agree that a photographic copy of this authorization shall be as valid as the original, and that this authorization shall be valid for 2 ½ years from the date shown below. I understand the information obtained by use of this authorization may be used by the Plan Sponsor, claims or third party administrator, and any excess loss insurance carrier designated by the Plan to determine my eligibility for health coverage, and eligibility for benefits under an existing plan. Any information obtained will not be released to any person or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my enrollment for the coverage, for any claim, for medical management purposes, or as may be otherwise lawfully required or as I may further authorize. I also understand that I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. Should I refuse to sign this authorization, I understand it may affect my enrollment in the benefit plan. All pages must be attached and complete, including this authorization for the application to be considered complete. Incomplete applications may be rejected.

Enrollee Signature X _____ Date (required) _____ If signed by a representative of enrollee, please indicate

the representative's authority to act on behalf of enrollee.