SafeGuard Wisconsin

Employee Enrollment and Addendum to the Employer Disclosure Excess Loss Insurance - Short Medical Form

A. Employee Information

Employer Name_____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced Date of Marriage _____ Date of Divorce _____

First Name _____ MI_____ Last _____

Address_____

City_____ State_____ Zip_____

Date of Birth _____ Social Security Number_____

Occupation_____ Date of Hire_____

Daytime Phone Number_____ Email Address_____

Height_____ Weight_____

Are you COBRA eligible? ☐ Yes ☐ No If yes, qualifying event date_____ Beginning of COBRA coverage_____

Life Insurance: Beneficiary Name_____ Relationship_____

B. Dependent Information*

Are you enrolling dependents? ☐ Yes ☐ No If so, please complete the following for each enrolling individual.

First Name	MI	Last Name	Relationship	Date of Birth	Sex	Height	Weight	Social Security No.**

Dependent name and address (if address is different than your own) Name_____

Address_____

**If you enroll dependents with a different last name, you must provide proof of relationship (copy of adoption form, birth certificate, tax return or marriage certificate). ** Required by Federal and State law. We cannot process your enrollment form without it.*

C. Other Insurance Information

Other than existing employer provided coverages, are you or any of your eligible dependents covered under any of the following other medical insurance coverages? ☐ Yes ☐ No

Source	Who is Covered?	Name of Covered	Effective Date	Name of Carrier	Type of Coverage
Spousal	☐ You ☐ Spouse ☐ Dependent				☐ Med. ☐ Rx
Individual Plan	☐ You ☐ Spouse ☐ Dependent				☐ Med. ☐ Rx
Medicaid	☐ You ☐ Spouse ☐ Dependent				☐ Med. ☐ Rx
Medicare	☐ You ☐ Spouse ☐ Dependent				☐ Med. ☐ Rx

Reason for Medicare eligibility ☐ Age 65 or Over ☐ Disabled ☐ Kidney Disease Date Eligible_____

Type of Medicare Coverage (check all that apply): ☐ Part A ☐ Part B ☐ Part D

D. Family Medical Questions

During the past year, have you or your dependents been diagnosed, treated, received counseling or advice for pregnancy or suspected pregnancy, or used any pregnancy testing device or test? ☐ Yes ☐ No

If Yes, please provide details, including but not limited to, the results from the pregnancy testing device or test, the diagnosis, and the kind of treatment.

During the past five years, have you or your dependents been diagnosed, treated (including prescription drugs), received counseling or advice for a spine disorder, heart disorder, cancer, kidney disorder, liver disorder, arthritis or a bleeding/coagulation disorder?
☐ Yes ☐ No

If Yes, please provide details, including but not limited to, the medical condition, diagnosis and the current prescription drugs.

Would you like to add additional explanations? ☐ Yes ☐ No If so, please indicate which section you are referencing.

E. Employee Agreement/Authorization to Release HIPAA Medical Information

This section must be completed.

I declare: (1) all statements in this form are true to the best of my knowledge; (2) I have not withheld or omitted any material information. **I understand my answers support the Employer Disclosure Form and Application for Excess Loss Insurance.** I understand any misstatement about medical history could result in voiding or reformation of the excess loss insurance policy issued to my employer. I certify I read the entire completed form. I understand no agent has authority to bind or alter coverage.

I authorize the Authorized Disclosers to give USHL or its legal representative any information about me or my dependents as to: (1) diagnosis, treatment and prognosis of any physical or mental condition; (2) drug or alcohol abuse; HIV/AIDS test results, or diagnosis and/or treatment; (3) non-medical information.

Authorized Disclosers: physicians; medical practitioners; hospitals; clinics; veterans administration facilities; other medical or medically related facilities; pharmacy benefit managers; insurers; reinsurers.

I understand USHL uses the information obtained to determine whether to issue an Excess Loss Policy to my Employer.

My protected health information (PHI) is: (1) individually identifiable health information, including demographic information; (2) collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse. This information must relate to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize USHL to use and disclose my PHI only for the purposes of administering the Excess Loss Insurance Policy issued to my Employer. I understand USHL may refuse to issue the Excess Loss Insurance Policy to my Employer if I refuse to sign this authorization.

I can revoke this authorization at any time. I must send a written revocation to USHL at 8220 Irving Road, Sterling Heights, MI 48312. The revocation is effective only for future uses and disclosures of PHI. The revocation is not effective: (i) for information USHL already used or disclosed relying on this authorization or (ii) if the authorization was obtained as a condition of coverage.

USHL will not release any information except: to reinsurers or other persons or organizations performing business or legal services in connection with this disclosure form; for any claims; or as may be lawfully required; or as I may further authorize. Information that USHL re-discloses may not be protected by federal privacy laws.

I may request a copy of this authorization at any time. This authorization is valid for 30 months from the date I sign it.

Employee Signature_____ Date_____

Spouse Signature_____ Date_____

(Required if spouse is enrolling for coverage)

Child Signature_____ Date_____

(Required if child age 18 or older is enrolling for coverage)

Child Signature_____ Date_____

(Required if child age 18 or older is enrolling for coverage)

Child Signature_____ Date_____

(Required if child age 18 or older is enrolling for coverage)

Fraud Warning: Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

For Office Use Only

EFF DATE _____ MED _____ CLASS _____

DIVISION # _____ DEN _____ LIFE _____

SafeGuard Wisconsin

8220 Irving Road
Sterling Heights, MI 48312
844-828-5968 • www.safeguardwisconsin.com