

A. Employer Information This section to be completed by employer.

New Hire Rehire (within 6 months) Status Change Beneficiary Change Reapply After Waiver
 Open Enrollment Name Change Address Change Other _____

Effective Date _____ If Status Change, what is the reason for the change (e.g. COBRA)? _____

Group (Employer) Name _____ Group ID/Div# _____

Date of Hire _____ Class _____

B. Employee Information

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 _____

Daytime Phone Number _____ Email Address _____

Are you COBRA eligible? Yes No If yes, qualifying event date _____ Beginning of COBRA coverage _____

Life Insurance Beneficiary Name _____ Relationship _____

C. Dependent Information*

Are you (enrolling adding or removing) your eligible (spouse and/or children)?

Please complete the following for each enrolling individual.

First Name	MI	Last Name	Relationship	Date of Birth	Sex	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.*

D. 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	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	_____	_____	_____	<input type="checkbox"/> Med. <input type="checkbox"/> Rx <input type="checkbox"/> Dental
Individual Plan	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	_____	_____	_____	<input type="checkbox"/> Med. <input type="checkbox"/> Rx <input type="checkbox"/> Dental
Medicaid	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	_____	_____	_____	<input type="checkbox"/> Med. <input type="checkbox"/> Rx <input type="checkbox"/> Dental
Medicare	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	_____	_____	_____	<input type="checkbox"/> Med. <input type="checkbox"/> Rx <input type="checkbox"/> Dental

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

E. Employee Agreement/Authorization to Release HIPAA Medical Information This section must be completed.

I apply to US Health and Life Insurance Company (USHL) for coverage. 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 are the basis for USHL to issue a plan document. I agree that USHL is not bound by any statement made by or to any agent unless written in this form. I understand any misstatement could result in: denial of a valid claim; and voiding or reformation of coverage. 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 eligibility: (1) for new coverage; (2) for benefits under any existing plan.

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 plan document subject of this enrollment form. I understand USHL may refuse to enroll me or determine that I am not eligible for benefits 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 my application for coverage; 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)

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 coverage fraud and subject to criminal and/or civil penalties.

For Office Use Only	
EFF DATE _____	MED _____
CLASS _____	DIVISION # _____
DEN _____	LIFE _____



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underwritten by US Health and Life Insurance Company.
SafeGuard plans administered by US Health and Life Insurance Company.
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