



# Employee Enrollment Form

**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.



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|  |
|--|
| For Office Use Only  |
| Group/division _____   |
| What action was taken ex: single to couple or couple to single _____ |
| Effective date of change _____                                       |
| Coverage level _____   |

Excess loss insurance policies and PPO insurance plans underwritten by US Health and Life Insurance Company. SafeGuard plans administered by US Health and Life Insurance Company. © US Health and Life Insurance Company. All rights reserved.