USHL
US Health and Life
US HEALTH AND LIFE INSURANCE COMPANY

Employee Enrollment Form
Large Employer Group - Insured (MI)

A. Employer Information To be completed by employer

☐ Initial Group Enrollment ☐ New Hire ☐ Rehire (within 6 months) ☐ Status Change
☐ Reapply After Waiver ☐ Open Enrollment ☐ Other

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

Group (Employer) Name_____ Division_____

Date of Hire_____ Hours worked per week:_____ Salary_____ Initials_____

B. Employee Information This section must be completed

Coverage Selection ☐ Medical ☐ Dental

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

First Name _____ MI_____ Last _____ ☐ Name Change

Address_____ ☐ Address Change

City_____ State_____ Zip_____

Date of Birth _____ Social Security Number_____

Occupation_____

Daytime Phone Number_____ Height_____ Weight_____

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

Life Insurance: Beneficiary Name_____

Relationship_____ ☐ Beneficiary Change

C. Waiver This section must be completed if declining to enroll

I decline to enroll for ☐ medical coverage and/or ☐ dental coverage for

☐ myself ☐ my spouse and/or ☐ my children due to:

☐ Spousal coverage ☐ Existence of other health/dental coverage ☐ Other reason (explain)_____

Check one of the above boxes, then read and sign.

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage will be subject to treatment as a late enrollee and I may only apply at the next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such other health coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependent, provided that I request enrollment within 30 days after such marriage, birth, adoption or placement for adoption. I have read and understand the "Important Information" located on the last page of this form.

Sign below if declining coverage

Employee Signature_____ Date_____

D. Medical History Overview This section must be completed if enrolling for coverage

Have you or any of your dependents to be covered under this plan:
Been examined by a physician, psychiatrist, psychologist or other practitioner within the past five years and:

1	Been diagnosed with cancer, stroke, diabetes, heart or vascular disease, muscular, or systemic disease (including, but not limited to arthritis or lupus), HIV or AIDs, liver, kidney, lung, or intestinal disorder, infertility, transplant (recommended, pending or completed) or growth disorder?	☐ Yes ☐ No
2	Been treated for alcohol or drug abuse, or for a mental or emotional disorder?	☐ Yes ☐ No
3	Have incurred medical claims in excess of $5,000 in the past twelve months?	☐ Yes ☐ No
4	Been prescribed medications and/or are taking medication for the treatment of an on-going or chronic condition?	☐ Yes ☐ No
5	Are pregnant?	☐ Yes ☐ No
6	Been advised that surgery or treatment is needed or pending?	☐ Yes ☐ No

Please continue to section E. If you answered "No" to all of these questions, you may skip Section F.

E. Dependent Information This section must be completed when enrolling your dependents (use additional paper if necessary)

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

Please complete the following for each affected individual.

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

Dependent address (if different than your own) Dependent_____ 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 license). ** Required by Federal and State law. We cannot process your enrollment form without it.*

F. Medical History Complete only if you answered "Yes" in section D on page one and are enrolling for coverage

Have you or your dependents been diagnosed, treated, received counseling or advice during the past five years for any of the following:

PLEASE CHECK "YES" OR "NO" AND EXPLAIN ALL "YES" ANSWERS. USE AN ADDITIONAL PAGE IF NEEDED.

Cancer/Tumor ☐ Yes ☐ No

☐ Lung ☐ Breast ☐ Liver ☐ Colon ☐ Leukemia/Lymphoma ☐ Melanoma

☐ Prostate ☐ Kidney ☐ Bladder ☐ Throat ☐ Other

Patient Name_____ Date Diagnosed_____ Treatment_____

Date Last Treated_____ Current Status_____ Stage/Level_____

Treating Physician(s)_____

Heart/Circulatory ☐ Yes ☐ No

☐ Varicose Veins ☐ Skin Ulcer ☐ Phlebitis ☐ Stroke ☐ Congestive Heart Failure

☐ Heart Disease ☐ Blood Disorder ☐ Hemophilia ☐ Aneurysm

Bypass/Angioplasty (# of vessels involved)_____

High Blood Pressure (Last 3 readings & dates of readings)_____

High Cholesterol (Most recent reading & date of reading)_____

Patient Name_____ Date Diagnosed_____ Treatment_____

Date Last Treated_____ Current Status_____

Treating Physician(s)_____

Reproductive ☐ Yes ☐ No

☐ Current Pregnancy (Due date:_____) ☐ Multiples Expected_____ ☐ Breast Disorders

☐ Pregnancy Complications (current or past) ☐ Infertility ☐ Endometriosis

☐ Other_____

Patient Name_____ Date Diagnosed_____ Treatment_____

Date Last Treated_____ Current Status_____

Treating Physician(s)_____

Intestinal/Endocrine ☐ Yes ☐No

☐ Gallbladder ☐ Hepatitis B/C ☐ Crohn's/Ulcerative Colitis ☐ Hiatal Hernia/GI Reflux ☐ Ulcer

☐ Thyroid Disorder ☐ Liver Disorder ☐ Chronic Pancreatitis ☐ Colon Disorder (provide diagnosis)

☐ Other_____

☐ Diabetes Last Hemoglobin A1C_____ Fasting Blood Sugar_____

Patient Name_____ Date Diagnosed_____ Treatment_____

Date Last Treated_____ Current Status_____

Treating Physician(s)_____

Brain/Nervous ☐ Yes ☐No

☐ Multiple Sclerosis ☐ Paralysis ☐ Cerebral Palsy ☐ Migraines ☐ Alzheimer's Disease

☐ Parkinson's Disease ☐ Epilepsy (Type & date of last seizure)_____

☐ Other_____

Patient Name_____ Date Diagnosed_____ Treatment_____

Date Last Treated_____ Current Status_____

Treating Physician(s)_____

Immune ☐ Yes ☐No

☐ Lupus ☐ HIV ☐ AIDS ☐ Other_____

Patient Name_____ Date Diagnosed_____ Treatment_____

Date Last Treated_____ Current Status_____

Treating Physician(s)_____

Lungs/Respiratory ☐ Yes ☐No

☐ Asthma ☐ Allergies ☐ Cystic Fibrosis ☐ Pneumonia ☐ Emphysema / Chronic Bronchitis

☐ Sleep Apnea ☐ Tuberculosis ☐ Other_____

Patient Name_____ Date Diagnosed_____ Treatment_____

Date Last Treated_____ Current Status_____

Treating Physician(s)_____

Eyes/Ears/Nose/Throat ☐ Yes ☐No

☐ Retinopathy ☐ Cleft lip/palate ☐ Chronic Sinusitis ☐ Deviated Septum ☐ Chronic Ear Infections

☐ Glaucoma ☐ Cataracts ☐ Acoustic Neuroma ☐ Other_____

Patient Name_____ Date Diagnosed_____ Treatment_____

Date Last Treated_____ Current Status_____

Treating Physician(s)_____

Bones/Muscles ☐ Yes ☐No

☐ Joint Injury ☐ Pituitary Dwarfism ☐ Bulging/Herniated Disc ☐ Other Back/Neck Disorders

☐ Spina Bifida ☐ Pulled/Strained Muscle ☐ Arthritis (Rheumatoid or Osteo) ☐ Other_____

Patient Name_____ Date Diagnosed_____ Treatment_____

Date Last Treated_____ Current Status_____

Treating Physician(s)_____

Urinary/Kidney ☐ Yes ☐No

☐ Renal Failure ☐ Kidney Stones ☐ Neurogenic Bladder ☐ Polycystic Kidney Disease

☐ Prostate Disorder ☐ Other_____

Patient Name_____ Date Diagnosed_____ Treatment_____

Date Last Treated_____ Current Status_____

Treating Physician(s)_____

Mental Health/Substance Abuse ☐ Yes ☐No

☐ Alcoholism ☐ Eating Disorder ☐Bipolar/Manic Depression ☐Attention Deficit Disorder

☐ Drug Abuse ☐ Suicide Attempt ☐Anxiety/Depression ☐Other_____

Patient Name_____ Date Diagnosed_____ Treatment_____

Date Last Treated_____ Current Status_____

Treating Physician(s)_____

Transplant ☐ Yes ☐No

☐ Organ_____ ☐ Bone Marrow ☐ Discussed possible future transplant

☐ Surgery completed (Date:_____)

Patient Name_____ Current Status_____

Treating Physician(s)_____

Medication ☐ Yes ☐No

Member/Dependent Name	Medication	Condition	Daily Dosage	Frequency

Additional medication? ☐ Yes ☐No If "Yes," please attach sheet.

Other ☐ Yes ☐No

☐ Treatment, surgery or diagnostic testing discussed or advised, but not yet done ☐ Abnormal test or physical results

☐ Condition or congenital disorder not mentioned above ☐ Unexplained weight change

Patient Name_____ Date_____

Details_____

Treating Physician(s)_____

Tobacco Use ☐ Yes ☐No

☐ Has anyone on this enrollment form smoked or used tobacco products during the past 12 months?

Name(s)_____

Please give the name and telephone number of your current physician(s).

_____

_____

_____

Additional Explanations: Please attach a sheet if additional explanation is needed and indicate which section you are referencing.

G. Other Insurance Information Only complete this section after section E and if enrolling in coverage

Other than existing employer provided coverages, are you or any of your eligible dependents covered under any of the following other medical insurance coverages:

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

Reason for Medicare eligibility

☐ Age 65 or Over (Who_____; Date Eligible_____)

☐ Disabled (Who_____; Date Eligible_____)

☐ Kidney Disease (Who_____; Date Eligible_____)

Type of Medicare Coverage

Name_____ Medicare Card ID_____ Effective Date_____

☐Part A ☐Part B ☐Part D

Name_____ Medicare Card ID_____ Effective Date_____

☐Part A ☐Part B ☐Part D

Name_____ Medicare Card ID_____ Effective Date_____

☐Part A ☐Part B ☐Part D

H. 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 certificate of insurance. I agree that USHL is not bound by any statement made by or to any agent unless written in this form. I understand any fraud or intentional misstatement about medical history will result in: denial of a valid claim; and rescission, voiding or reformation of insurance. 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 insurance; (2) for benefits under any existing policy.

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 insurance certificate including but not limited to treatment, payment and health care operations activities. 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 insurance; 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 anytime. 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 _____

DIVISION # _____ DEN _____ LIFE _____

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