

<b>A. Employer Information</b>		To be completed by employer				
<input type="checkbox"/> Initial Group Enrollment		<input type="checkbox"/> New Hire		<input type="checkbox"/> Rehire (within 6 months)		<input type="checkbox"/> Status Change
<input type="checkbox"/> Reapply After Waiver		<input type="checkbox"/> Open Enrollment		<input type="checkbox"/> 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>B. Employee Information</b>		This section must be completed				
Coverage Selection		<input type="checkbox"/> Medical		<input type="checkbox"/> Dental		
<input type="checkbox"/> Male		<input type="checkbox"/> Female		<input type="checkbox"/> Single		<input type="checkbox"/> Married
<input type="checkbox"/> Divorced		Date of Marriage or Divorce _____				
First Name _____		MI _____	Last _____		<input type="checkbox"/> Name Change	
Address _____					<input type="checkbox"/> Address Change	
City _____			State _____		Zip _____	
Date of Birth _____		Social Security Number _____				
Daytime Phone Number _____			Occupation _____			
Are you COBRA eligible?		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, qualifying event date _____		Beginning of COBRA coverage _____
Life Insurance: Beneficiary Name _____						
Relationship _____					<input type="checkbox"/> Beneficiary Change	
<b>C. Dependent Information</b>		This section must be completed when enrolling your dependents (use additional paper if necessary)				
Are you ( <input type="checkbox"/> enrolling <input type="checkbox"/> adding or <input type="checkbox"/> removing) your eligible ( <input type="checkbox"/> spouse and/or <input type="checkbox"/> children)?*						
Please complete the following for each affected individual.						
First Name	MI	Last Name	Relationship	Date of Birth	Sex	Social Security No.**
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
Dependent address (if different than your own) Dependent _____ Address _____						
<i>*If you are enrolling dependents, other than at time of Initial Enrollment, you must provide proof of relationship (copy of adoption form, birth certificate, tax return or marriage license). If you are enrolling dependents with a different last name at Initial Enrollment, you must provide proof of relationship (copy of adoption form, birth certificate, tax return or marriage license).</i>						
<b>D. Tobacco Use</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Has anyone on this enrollment form smoked or used tobacco products during the past 12 months?						
Name(s) _____						

<b>E. Waiver</b> This section must be completed if declining to enroll					
I decline to enroll for <input type="checkbox"/> medical coverage and/or <input type="checkbox"/> dental coverage for					
<input type="checkbox"/> myself <input type="checkbox"/> my spouse and/or <input type="checkbox"/> my children due to:					
<input type="checkbox"/> Spousal coverage <input type="checkbox"/> Existence of other health/dental coverage <input type="checkbox"/> Other reason (explain) _____					
<i>Check one of the above boxes, then read and sign.</i>					
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.					
<i>Sign below if declining coverage</i>					
Employee Signature _____				Date _____	
<b>F. Other Insurance Information</b> 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	<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
<b>Reason for Medicare eligibility</b>					
<input type="checkbox"/> Age 65 or Over (Who _____; Date Eligible _____)					
<input type="checkbox"/> Disabled (Who _____; Date Eligible _____)					
<input type="checkbox"/> Kidney Disease (Who _____; Date Eligible _____)					
<b>Type of Medicare Coverage</b>					
Name _____ Medicare Card ID _____ Effective Date _____					
<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D					
Name _____ Medicare Card ID _____ Effective Date _____					
<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D					
Name _____ Medicare Card ID _____ Effective Date _____					
<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D					

**G. 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 misrepresentation 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 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 \_\_\_\_\_



US Health and Life

US HEALTH AND LIFE INSURANCE COMPANY

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800-211-1538 • www.ushealthandlife.com