ID Number_____

USHL SafeGuard
US Health and Life
US HEALTH AND LIFE INSURANCE COMPANY

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	☐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 ☐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_____