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

Employee Enrollment and Addendum to the Employer Disclosure Excess Loss Insurance - Full Medical Form

A. Employee Information

Employer Name_____

☐ 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_____ Date of Hire_____

Daytime Phone Number_____ Email Address_____

Height_____ Weight_____

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

Life Insurance: Beneficiary Name_____ Relationship_____

B. Dependent Information*

Are you enrolling dependents? ☐ Yes ☐ No If so, please complete the following for each enrolling individual.

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

C. 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
Individual Plan	☐ You ☐ Spouse ☐ Dependent				☐ Med. ☐ Rx
Medicaid	☐ You ☐ Spouse ☐ Dependent				☐ Med. ☐ Rx
Medicare	☐ You ☐ Spouse ☐ Dependent				☐ Med. ☐ Rx

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

D. Medical History Overview

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, or an Aids-related condition; liver, kidney, lung, or intestinal disorder, infertility, transplant (recommended, pending or completed) or growth disorder? (Regarding HIV, this does not include an initial positive result that further testing showed to be false.)	☐ 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

E. Medical History

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 ADDITIONAL EXPLANATIONS PAGE AT END OF THIS SECTION 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 ☐ 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 use additional explanations 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).

_____

_____

_____

_____

Would you like to add additional explanations? ☐ Yes ☐ No If so, please indicate which section you are referencing.

E. Employee Agreement/Authorization to Release HIPAA Medical Information

This section must be completed.

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 support the Employer Disclosure Form and Application for Excess Loss Insurance.** I understand any misstatement about medical history could result in voiding or reformation of the excess loss insurance policy issued to my employer. 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 whether to issue an Excess Loss Policy to my Employer.

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 Excess Loss Insurance Policy issued to my Employer. I understand USHL may refuse to issue the Excess Loss Insurance Policy to my Employer 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 this disclosure form; 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)

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 _____ CLASS _____

DIVISION # _____ DEN _____ LIFE _____

USHL

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SafeGuard

8220 Irving Road
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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.