

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	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	_____	_____	_____	<input type="checkbox"/> Med. <input type="checkbox"/> Rx
Individual Plan	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	_____	_____	_____	<input type="checkbox"/> Med. <input type="checkbox"/> Rx
Medicaid	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	_____	_____	_____	<input type="checkbox"/> Med. <input type="checkbox"/> Rx
Medicare	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	_____	_____	_____	<input type="checkbox"/> Med. <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Hepatitis B/C	<input type="checkbox"/> Crohn's/Ulcerative Colitis	<input type="checkbox"/> Hiatal Hernia/GI Reflux	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Liver Disorder	<input type="checkbox"/> Chronic Pancreatitis	<input type="checkbox"/> Colon Disorder (provide diagnosis)	
<input type="checkbox"/> Other _____				
<input type="checkbox"/> Diabetes	Last Hemoglobin A1C _____		Fasting Blood Sugar _____	
Patient Name _____		Date Diagnosed _____	Treatment _____	
Date Last Treated _____		Current Status _____		
Treating Physician(s) _____				
Brain/Nervous <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Migraines	<input type="checkbox"/> Alzheimer's Disease
<input type="checkbox"/> Parkinson's Disease		<input type="checkbox"/> Epilepsy (Type & date of last seizure) _____		
<input type="checkbox"/> Other _____				
Patient Name _____		Date Diagnosed _____	Treatment _____	
Date Last Treated _____		Current Status _____		
Treating Physician(s) _____				
Immune <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Lupus	<input type="checkbox"/> Other _____			
Patient Name _____		Date Diagnosed _____	Treatment _____	
Date Last Treated _____		Current Status _____		
Treating Physician(s) _____				
Lungs/Respiratory <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergies	<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Emphysema / Chronic Bronchitis
<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Other _____		
Patient Name _____		Date Diagnosed _____	Treatment _____	
Date Last Treated _____		Current Status _____		
Treating Physician(s) _____				
Eyes/Ears/Nose/Throat <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Retinopathy	<input type="checkbox"/> Cleft lip/palate	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Deviated Septum	<input type="checkbox"/> Chronic Ear Infections
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Acoustic Neuroma	<input type="checkbox"/> Other _____	
Patient Name _____		Date Diagnosed _____	Treatment _____	
Date Last Treated _____		Current Status _____		
Treating Physician(s) _____				
Bones/Muscles <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Joint Injury	<input type="checkbox"/> Pituitary Dwarfism	<input type="checkbox"/> Bulging/Herniated Disc	<input type="checkbox"/> Other Back/Neck Disorders	
<input type="checkbox"/> Spina Bifida	<input type="checkbox"/> Pulled/Strained Muscle	<input type="checkbox"/> Arthritis (Rheumatoid or Osteo)	<input type="checkbox"/> Other _____	
Patient Name _____		Date Diagnosed _____	Treatment _____	
Date Last Treated _____		Current Status _____		
Treating Physician(s) _____				

Urinary/Kidney <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Renal Failure <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Neurogenic Bladder <input type="checkbox"/> Polycystic Kidney Disease				
<input type="checkbox"/> Prostate Disorder <input type="checkbox"/> Other _____				
Patient Name _____		Date Diagnosed _____		Treatment _____
Date Last Treated _____		Current Status _____		
Treating Physician(s) _____				
Mental Health/Substance Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Alcoholism <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Bipolar/Manic Depression <input type="checkbox"/> Attention Deficit Disorder				
<input type="checkbox"/> Drug Abuse <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> Other _____				
Patient Name _____		Date Diagnosed _____		Treatment _____
Date Last Treated _____		Current Status _____		
Treating Physician(s) _____				
Transplant <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Organ _____ <input type="checkbox"/> Bone Marrow <input type="checkbox"/> Discussed possible future transplant				
<input type="checkbox"/> Surgery completed (Date: _____)				
Patient Name _____		Current Status _____		
Treating Physician(s) _____				
Medication <input type="checkbox"/> Yes <input type="checkbox"/> No				
Member/Dependent Name	Medication	Condition	Daily Dosage	Frequency
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Additional medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please use additional explanations sheet.				
Other <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Treatment, surgery or diagnostic testing discussed or advised, but not yet done			<input type="checkbox"/> Abnormal test or physical results	
<input type="checkbox"/> Condition or congenital disorder not mentioned above			<input type="checkbox"/> Unexplained weight change	
Patient Name _____			Date _____	
Details _____				
Treating Physician(s) _____				
Tobacco Use <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) _____				
Please give the name and telephone number of your current physician(s).				

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 _____



US Health and Life

US HEALTH AND LIFE INSURANCE COMPANY



8220 Irving Road

Sterling Heights, MI 48312

844-828-5968 • www.ushealthandlife.com

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