Employee Enrollment Form

US HEALTH AND LIFE
INSURANCE COMPANY

8220 Irving Road
Sterling Heights, MI 48312
1-800-211-1538
www.ushealthandlife.com

Please complete this form as accurately as possible.
Be sure to check all applicable boxes.

A. Employer Information — To be completed by employer

☐ Initial Group Enrollment ☐ New Hire ☐ Re-Hire (within 6 months) ☐ Status Change ☐ Re-Apply After Waiver ☐ Open Enrollment ☐ Other_______________

Effective Date:___________________________

Employer Name:___________________________ Division:___________________________

Month/Day/Year of Hire:___________________________ Class:_______________ Salary:_______________

B. Employee Information — This section must be completed

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced Date of Marriage or Divorce:_______________

Name:___________________________ ☐ Name Change
(First) (M.I.) (Last)

Address: ___________________________ ☐ Address Change

City: _______________ State: _______________ Zip: _______________

Date of Birth: _______________ Social Security Number: _______________ Occupation: _______________

Daytime Phone Number: _______________ Height: _______________ Weight: _______________

Life Insurance: Beneficiary Name:_______________ Relationship:_______________ ☐ Beneficiary Change

Is this person COBRA eligible? ☐ Yes ☐ No If yes, qualifying event date:____________ Beginning of COBRA coverage:____________

C. Dependent Information — This section must be completed when enrolling your dependents

Are you [☐ enrolling ☐ adding or ☐ removing] your eligible [☐ spouse and/or ☐ dependents]?*
Please complete the following for each effected individual.

*If you enroll Dependents with a different last name, you must provide proof of dependency (copy of adoption form, birth certificate, tax return or marriage license)

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

If any of the dependents you listed above (other than your spouse) are 19 or older and full-time students, please complete a Student Verification Form (available from either your agent or www.ushealthandlife.com) and submit it with this application and a current transcript or enrollment form.

D. WAIVER — This section must be completed if declining to enroll

I decline to enroll for this coverage for myself, my spouse, and my dependent children due to:
☐ Spousal coverage ☐ Existence of other health 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 back of this form.

Employee Signature:___________________________ **Date:**_______________
(Sign here if you are declining coverage)

E. Medical History Overview — This section must be completed if accepting coverage

Have you or any of your dependents to be covered under this plan been examined by a doctor, psychiatrist, psychologist or other practitioner within the past 24 months and;

1. Diagnosed with cancer, stroke, diabetes, heart or vascular disease, mental or emotional disorder, muscular or systematic disease (including, but not limited to arthritis, lupus), alcohol or drug use, liver, kidney, lung or intestinal disorder, infertility, transplant (recommended, pending or completed) or growth disorder? ☐ Yes ☐ No
2. Incurred medical claims in excess of $5,000? ☐ Yes ☐ No
3. Have been prescribed medications for the treatment of an on-going or chronic condition? ☐ Yes ☐ No
4. Been advised of a pregnancy? ☐ Yes ☐ No
5. Been advised that surgery or treatment is needed or pending? ☐ Yes ☐ No

If you have answered Yes to any of these questions please be sure to complete Section G, otherwise you may skip that section.

F. 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	____________	______	____________	☐ Medical ☐ Rx ☐ Dental
Individual Plan	☐ You ☐ Spouse ☐ Dependent	____________	______	____________	☐ Medical ☐ Rx ☐ Dental
Medicaid	☐ You ☐ Spouse ☐ Dependent	____________	______	____________	☐ Medical ☐ Rx ☐ Dental
Medicare	☐ You ☐ Spouse ☐ Dependent	____________	______	____________	☐ Medical ☐ Rx ☐ Dental

Reason for Medicare eligibility ☐ Age 65 or Over ☐ Disabled ☐ Kidney Disease Date Eligible:____________________

Have you received a Certificate of Creditable Coverage in the last 15 months?
☐ Yes ☐ No If yes, please attach the certificate to this application

G. Medical History

Complete only if you answered yes in section E

Have you or your dependents been diagnosed, treated, received counseling or advice during the past 5 years for any of the following: PLEASE CHECK AND EXPLAIN ALL THAT APPLY. USE AN ADDITIONAL PAGE IF NEEDED.

Cancer/Tumor
☐ Yes ☐ No

☐ Lung ☐ Breast ☐ Liver ☐ Colon ☐ Leukemia/Lymphoma
☐ Melanoma ☐ Prostate ☐ Other: ____________________

Patient Name:____________________ Date Diagnosed: __________Treatment: ______________
Date Last Treated: ________________ Current Status:____________ Stage/Level: ______________

Heart/Circulatory
☐ Yes ☐ No

☐ Varicose Veins ☐ Skin Ulcer ☐ Phlebitis ☐ Stroke ☐ Aneurysm
☐ Blood Disorder ☐ Hemophilia ☐ Heart Disease ☐ Congestive Heart Failure
☐ 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:________________________________

Reproductive
☐ Yes ☐ No

☐ Current Pregnancy (Due date: __________) ☐ Multiples Expected____________
☐ Pregnancy Complications (current or past) ☐ Infertility ☐ Endometriosis
☐ Breast Disorders ☐ Other____________________________

Patient Name:____________________ Date Diagnosed: __________Treatment: ______________
Date Last Treated: ______________ Current Status:__________________________________

Intestinal/ Endocrine
☐ Yes ☐ No

☐ Gallbladder ☐ Liver Disorder ☐ Hepatitis B/C ☐ Colon Disorder (provide diagnosis)
☐ Thyroid Disorder ☐ Crohn's/Ulcerative Colitis ☐ Diabetes ☐ Ulcer
☐ Chronic Pancreatitis ☐ Hiatal Hernia/GI Reflux

Last Hemoglobin A1C____________ Fasting Blood Sugar ______________ Other____________
Patient Name:____________________ Date Diagnosed: __________Treatment: ______________
Date Last Treated: ________________ Current Status: ________________________________

Brain/Nervous
☐ Yes ☐ No

☐ Multiple Sclerosis ☐ Paralysis ☐ Cerebral Palsy ☐ Migraines
☐ Parkinson's Disease ☐ Alzheimer's Disease ☐ Epilepsy (Type & Date of last seizure)__________
☐ Other:____________

Patient Name:____________________ Date Diagnosed: __________Treatment: ______________
Date Last Treated: ________________ Current Status:________________________________

Immune
☐ Yes ☐ No

☐ Lupus ☐ HIV+ ☐ AIDS ☐ Other:____________________________

Patient Name: ____________________ Date Diagnosed: __________Treatment: ______________
Date Last Treated: ________________ Current Status: ________________________________

G. Medical History Continued

Only complete this section if enrolling for coverage

Lungs/Respiratory
☐ Yes ☐ No

☐ Asthma ☐ Allergies ☐ Cystic Fibrosis ☐ Emphysema / Chronic Bronchitis
☐ Pneumonia ☐ Tuberculosis ☐ Sleep Apnea ☐ Other:_______________

Patient Name:_______________ Date Diagnosed: _______________ Treatment: _______________
Date Last Treated:_______________ Current Status:_______________

Eyes/Ears/ Nose/Throat
☐ Yes ☐ No

☐ Retinopathy ☐ Cleft lip/palate ☐ Chronic Sinusitis ☐ Deviated Septum
☐ Acoustic Neuroma ☐ Glaucoma ☐ Cataracts ☐ Chronic Ear Infections
☐ Other: _______________

Patient Name:_______________ Date Diagnosed: _______________ Treatment: _______________
Date Last Treated: _______________ Current Status:_______________

Urinary/Kidney
☐ Yes ☐ No

☐ Renal Failure ☐ Polycystic Kidney Disease ☐ Neurogenic Bladder ☐ Kidney Stones
☐ Prostate Disorder ☐ Other:_______________

Patient Name:_______________ Date Diagnosed: _______________ Treatment: _______________
Date Last Treated: _______________ Current Status:_______________

Bones/Muscles
☐ Yes ☐ No

☐ Bulging/Herniated Disc ☐ Pituitary Dwarfism ☐ Spina Bifida ☐ Arthritis (Rheumatoid or Osteo)
☐ Joint Injury ☐ Pulled/Strained Muscle ☐ Other Back/Neck Disorders
☐ Other: _______________

Patient Name:_______________ Date Diagnosed: _______________ Treatment: _______________
Date Last Treated: _______________ Current Status:_______________

Mental Health/ Substance Abuse
☐ Yes ☐ No

☐ Bipolar/Manic Depression ☐ Eating Disorder ☐ Anxiety/Depression ☐ Alcoholism
☐ Drug Abuse ☐ Suicide Attempt ☐ Attention Deficit Disorder ☐ Other:_______________

Patient Name:_______________ Date Diagnosed:_______________ Treatment:_______________
Date Last Treated:_______________ Current Status:_______________

Transplant
☐ Yes ☐ No

☐ Organ _______________ ☐ Bone Marrow ☐ Surgery Completed (Date:_______________)
☐ Discussed possible future transplant

Patient Name:_______________ Current Treatment:_______________

Medication
☐ Yes ☐ No

Member/Dependent Name	Medication	Daily Dosage	Frequency

Other
☐ Yes ☐ No

☐ Treatment or surgery 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:_______________

Tobacco Use
☐ Yes ☐ No

Has anyone on this application smoked or used tobacco products during the past 12 months?
If Yes, Indicate the number of packs per day along with the number of years.

Packs/Day:_______________ Years:_______________
Name: _______________

Alcohol Use
☐ Yes ☐ No

How frequently do you drink alcohol? _______________ Type of alcohol: _______________

Please give the name and telephone number of your current doctor/doctors.

____
____
____

H. Employee Agreement/Authorization to Release HIPAA Medical Information   This section must be completed

Agreement: I apply to US Health and Life Insurance Company for coverage. I declare that all of the statements contained in this enrollment form, to the best of my knowledge, are true and correct, and that no material insurance information has been withheld or omitted concerning the past or present state of health of myself or of my named dependents. I understand that the above answers shall be the basis for the insurer to issue a certificate of insurance. I understand and agree that the insurer is not bound by any statement made by or to any agent unless documented in this enrollment form. I understand that any misstatements about medical history could result in denial of an otherwise valid claim and voiding or reformation of insurance.

I acknowledge reading the entire completed enrollment form and the insurance agent has explained the coverages, limitations and exclusions, other details of coverage of the insurance applied for, and the underwriting rules and regulations of the insurer. No agent has authority to bind or alter coverage.

I have read the notice explaining the use of the Medical Information Bureau. I authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau, or Consumer Reporting Agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and or HIV/AIDS test results or diagnosis and/or treatment of me or my named dependents and other non-medical information of me or my named dependents, to give to US Health and Life Insurance Company or its legal representative, any and all such information.

I understand the information obtained by use of this authorization will be used by the insurer to determine eligibility for insurance, and eligibility for benefits under any existing policy, for myself and my named dependents. Any information obtained will not be released by the insurer to any persons or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my application for insurance, for any claims, or as may be otherwise lawfully required or as I may further authorize.

I understand that I may request a copy of this authorization at anytime.

Your Privacy Is Protected

US Health and Life Insurance Company, like other health insurance companies, sometimes evaluates present and past medical history of applicants to determine their eligibility for certain policies.

With US Health and Life Insurance Company, this evaluation is limited to specific insurance policies; and the applications for those clearly show this requirement.

I authorize the use and disclosure of my protected health information as described below.

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates 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.

US Health and Life Insurance Company is authorized to use or disclose my protected health information. My protected health information will be used or disclosed only for the purposes of administering the insurance certificate subject of this application.

I understand that if I refuse to sign this authorization that US Health and Life Insurance Company may refuse to enroll me or determine that I am not eligible for benefits.

I understand that I may revoke this authorization at any time by sending a written notification to US Health and Life Insurance Company at 8220 Irving Road, Sterling Heights, MI 48312, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (I) for information that US Health and Life Insurance Company already has used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition of coverage.

Any information you give USHL or its insurer regarding your insurability will be treated strictly confidential. USHL, or its insurer, may make a brief report on information received with your application to the Medical Information Bureau. (A nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. P.O. Box 105, Essex Station, Boston, MA 02112. Phone: 617-426-3660). The Bureau, upon request from a member company to whom you may apply for insurance or to whom a claim for benefits may be submitted, will supply the company with such information. If you ask, the Bureau will arrange disclosure of the information in your file and you may seek to correct any inaccuracy in accordance with the Fair Credit Reporting Act procedures.

Employee Signature: ______________________________ Date: ______________________________

Spouse Signature: ______________________________ Date: ______________________________
(Required if spouse is enrolling for coverage)

For Office Use Only

RECV'D ____________	MED ____________
ENT'D ____________	DEN ____________
EFF DATE ____________	CLASS ____________
DIVISION # ____________	LIFE ____________