

EMPLOYEE ENROLLMENT - Self-Funded Medical Coverage

EMPLOYEE INFORMATION

Last Name _____	First Name _____	Initial _____
Address: _____ City _____ State _____ Zip _____ County _____		
Social Security Number: _____ - _____ - _____		E-Mail Address: _____
☐ Single ☐ Married	Gender: ☐ Male ☐ Female	Date of Birth ____/____/____ Height: _____ Weight _____
Phone Number: ☐ Home ☐ Cell _____ - _____ - _____		Date Employed Full-Time: ____/____/____
Average Hours Worked Per Week: _____ Annual Salary: \$ _____ Occupation: _____ Independent Contractor? ☐ Yes ☐ No		

EMPLOYEE WAIVER (Please complete if you are declining medical coverage)

Please check all of the following that apply. I waive medical coverage for: ☐ Employee ☐ Spouse ☐ Child (ren)

Please state the reason for waiving coverage: _____ Qualifying Coverage _____ Other _____

If I have waived coverage for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in the coverage, provided that I request enrollment within 31 days after my other coverage ends because of involuntary loss of other coverage (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll my dependents, provided that I request enrollment within 31 days after the date of the event. I further understand that if I am considered a late enrollee, I may be declined from coverage or excluded from coverage for a period of time as defined in and where permitted by law, and I may be required to provide, where allowed by law, Medical History satisfactory to the Plan Sponsor or Administrator, for myself and/or my dependents

FAMILY INFORMATION (ONLY for those applying for coverage)

First Name, M.I. (last name if different)	Date of Birth	Gender	Height	Weight	Social Security Number	Primary Care Physician's Name
Spouse:	/ /	☐ M ☐ F			/ /	
Child:	/ /	☐ M ☐ F			/ /	
Child:	/ /	☐ M ☐ F			/ /	
Child:	/ /	☐ M ☐ F			/ /	
Child:	/ /	☐ M ☐ F			/ /	

COVERAGE INFORMATION

Effective Date: ____/____/____

Coverage Type Selected: ☐ Employee Only ☐ Family ☐ Employee & Spouse ☐ Employee & Child (ren)

Name of Selected Medical Plan: _____ PPO Network Name: _____

Change Coverage Request: ☐ Marriage ☐ Divorce ☐ Adoption ☐ Court Order:

Date of Event (you may be required to provide proof of the event): ____/____/____

Attach a written and signed statement by the employer for a requested coverage effective date. Effective date may not be guaranteed

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ELIGIBILITY / OTHER INSURANCE

Currently, are you working full-time? ☐ Yes ☐ No If no, explain _____

☐ Y ☐ N Do you or any family members intend to keep other insurance coverage in addition to this coverage? If yes, list family members:

List the name of the other insurance company(ies) and the policy number(s): _____

List family members covered by Medicare and their effective date: _____

MEDICAL INFORMATION (REQUIRED)

1. ☐ Y ☐ N Are you or any dependent disabled, hospital confined, or pregnant? If pregnant, due date: ____/____/____

If pregnant, are you expecting a multiple birth / having complications / planning a C-Section? ☐ Y ☐ N

2. ☐ Y ☐ N Are you or any eligible dependent receiving treatment; taking medication; receiving follow up care; scheduled for or awaiting results of any tests, biopsies, procedures or lab work; been advised to have a test; or been advised of a condition that will require attention in the next twenty-four (24) months?

3. ☐ Y ☐ N Have you or any eligible dependent used tobacco products in the past twelve (12) months?

4. ☐ Y ☐ N Have you or any eligible dependent ever been declined, postponed, ridered, or rated up for medical, disability, or life insurance with another insurance carrier? If yes, please explain.

5. In the past five (5) years, have you or any eligible dependent to be insured had any symptoms, diagnosis, consultation, testing, treatment, follow up care, or taken any medication or received counseling for:

a. ☐ Yes ☐ No Cancer/Tumor

g. ☐ Yes ☐ No Diabetes

m. ☐ Yes ☐ No Infertility

b. ☐ Yes ☐ No Kidney Disorder
Disorder

h. ☐ Yes ☐ No Liver Disorder/Hepatitis

n. ☐ Yes ☐ No Respiratory/Lung

c. ☐ Yes ☐ No Stroke

i. ☐ Yes ☐ No Systemic Lupus/Multiple
Sclerosis

o. ☐ Yes ☐ No Organ/Tissue Transplants

d. ☐ Yes ☐ No Immune System Disorder

j. ☐ Yes ☐ No Mental Disorder
Alcohol/Drug Abuse

p. ☐ Yes ☐ No Neurological Disorder

e. ☐ Yes ☐ No Arthritis/Back/Joint Disorder

k. ☐ Yes ☐ No Heart/Blood/Vascular Disorder/
Hypertension

q. ☐ Yes ☐ No Acquired Immune
Deficiency Syndrome
(AIDS)/AIDS Related
Complex (ARC)/HIV

f. ☐ Yes ☐ No Intestinal/Digestive Disorder l. ☐ Yes ☐ No Birth Defects/Congenital Disorder

Please provide details to "Yes" answers, including information regarding last doctor visit and/or physical examination and all medications taken (attach extra pages if needed with signature and date.)

Question/Letter	Name	Illness/Impairment	Treatment Dates	Medication/Treatment/Surgery/Physician
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

EMPLOYEE AGREEMENT – SIGNATURE REQUIRED

*** TO BE A VALID APPLICATION, YOUR SIGNATURE AND THE DATE YOU SIGN IT ARE REQUIRED**

I understand that the previous answers will be relied upon by the Plan Sponsor in the issuance of a Summary Plan Description. I declare all statements contained in this entire form about me and my dependents are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand that my intentional misrepresentation of a material fact or my failure to report information about me or my dependents may be used as the basis to rescind, terminate or modify coverage for me or my dependents. Rescind means that the coverage was never in effect. I understand and agree that the Plan Sponsor is not bound by any statement made by or to any agent unless written herein. I agree that no coverage will be effective until the date specified by the Plan Sponsor in the Summary Plan Description. The actual effective date may not be the requested effective date. If I am now waiving medical benefits for myself and/or my dependents, I have read the entire Waiver provision, and understand the enrollment requirements if I make request for such benefits at a later date.

I authorize my employer to deduct the necessary contribution toward the benefits. I reserve the right to revoke this deduction authorization at any time upon my written notice. Benefits are effective only after approval by the Plan Sponsor or Administrator and satisfaction of any probationary period.

Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false information may be found guilty of fraud, which is a crime, in a court of law and may be subject to fines and confinement in prison. This will not be considered as a complete application unless all pages are attached and completed.

☐ I understand that information on this enrollment form is valid for a maximum of 60 days from the date of signature.

Employee Signature X _____ **Date (required)** _____

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR ENROLLMENT – SIGNATURE REQUIRED

Please clearly print all information.

I hereby authorize those physicians, medical practitioners, hospital, clinics, veteran's administration facilities, medical information services, urgent care facilities, pharmacy, pharmacy benefit manager, health plan, and other medical or medically related entities, insurance or reinsurance companies, and consumer reporting agencies that have information available as to the present or former physical health condition, including drug or alcohol or domestic abuse, as well as diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, and/or treatment of me or my dependents to release to Amwins Accident & Health Underwriters, LLC, the claims or third party administrator, any other excess loss insurance carrier designated by the Plan, or its legal representative, any and all such information, including, but not limited to, medical records, health care provider notes, laboratory tests and results, diagnoses, treatment, and prognoses. I understand the information obtained by use of this authorization may be used to determine eligibility for issuance of health coverage and eligibility for benefits under existing health coverage for me and my dependents. This authorization is not applicable to psychotherapy notes.

I agree that a photographic copy of this authorization shall be as valid as the original, and that this authorization shall be valid for 2 ½ years from the date shown below. I understand the information obtained by use of this authorization may be used by the Plan Sponsor, claims or third party administrator, and any excess loss insurance carrier designated by the Plan to determine eligibility for health coverage, and eligibility for benefits under an existing plan, for myself and my dependents. Any information obtained will not be released to any person or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my enrollment for the coverage, for any claim, for medical management purposes, or as may be otherwise lawfully required or as I may further authorize. I also understand that I have a right to revoke this authorization in writing at any time by sending written notice to 2593 Development Drive, Suite 200, Green Bay WI 54311, except to the extent information has been released in reliance upon this authorization. Should I refuse to sign this authorization, I understand it may affect my enrollment in the benefit plan. All pages must be attached and complete, including this authorization for the application to be considered complete. Incomplete applications may be rejected.

Employee Signature X _____ **Date** _____

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant:

Spouse Signature X _____ **Date** _____

Dependent(s) Age 18+ Signature X _____ **Date** _____