

Employee Enrollment Form



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: _____ If Status Change, what is the reason for the change (i.e. COBRA)?: _____

Group (Employer) Name: _____ Division: _____

Date of Hire (M/D/Y): _____ Class: _____ Salary: _____

B. Employee Information

This section must be completed

Coverage Selection: Medical Coverage Dental Coverage Both Male Female

Single Married Divorced Date of Marriage or Divorce: _____

Name: _____ Name Change
 (First) (M.I.) (Last)

Address: _____

City: _____ State: _____ Zip: _____ Address Change

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. Waiver

This section must be completed if declining to enroll

I decline to enroll in **Medical** coverage for myself, my spouse, and/or my dependent children due to:

Spousal coverage Existence of other health coverage Other reason (explain): _____

I decline to enroll in **Dental** coverage for myself, my spouse, and/or my dependent children due to:

Spousal coverage Existence of other health coverage Other reason (explain): _____

Check the applicable 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)

D. Dependent Information

This section must be completed when enrolling your dependents (use additional paper if necessary)

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.secureoneinc.com) and submit it with this application and a current transcript or enrollment form.

E. Medical History Overview

This section must be completed if enrolling for 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

F. Medical History

COMPLETE ONLY IF YOU ANSWERED YES IN SECTION E AND ARE ENROLLING FOR COVERAGE

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. ADDITIONAL SPACE PROVIDED BELOW. USE AN ADDITIONAL PAGE IF NEEDED.

Cancer/Tumor <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Lung <input type="checkbox"/> Breast <input type="checkbox"/> Liver <input type="checkbox"/> Colon <input type="checkbox"/> Leukemia/Lymphoma <input type="checkbox"/> Melanoma <input type="checkbox"/> Prostate <input type="checkbox"/> Other: _____ Patient Name: _____ Date Diagnosed: _____ Treatment: _____ Date Last Treated: _____ Current Status: _____ Stage/Level: _____
Heart/Circulatory <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Varicose Veins <input type="checkbox"/> Skin Ulcer <input type="checkbox"/> Phlebitis <input type="checkbox"/> Stroke <input type="checkbox"/> Aneurysm <input type="checkbox"/> Blood Disorder <input type="checkbox"/> Hemophilia <input type="checkbox"/> Heart Disease <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Pregnancy (Due date: _____) <input type="checkbox"/> Multiples Expected _____ <input type="checkbox"/> Pregnancy Complications (current or past) <input type="checkbox"/> Infertility <input type="checkbox"/> Endometriosis <input type="checkbox"/> Breast Disorders <input type="checkbox"/> Other _____ Patient Name: _____ Date Diagnosed: _____ Treatment: _____ Date Last Treated: _____ Current Status: _____
Intestinal / Endocrine <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Gallbladder <input type="checkbox"/> Liver Disorder <input type="checkbox"/> Hepatitis B/C <input type="checkbox"/> Colon Disorder (provide diagnosis) <input type="checkbox"/> Thyroid Disorder <input type="checkbox"/> Crohn's/Ulcerative Colitis <input type="checkbox"/> Diabetes <input type="checkbox"/> Ulcer <input type="checkbox"/> Chronic Pancreatitis <input type="checkbox"/> Hiatal Hernia/GI Reflux Last Hemoglobin A1C _____ Fasting Blood Sugar _____ Other _____ Patient Name: _____ Date Diagnosed: _____ Treatment: _____ Date Last Treated: _____ Current Status: _____
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"/> Parkinson's Disease <input type="checkbox"/> Alzheimer'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: _____
Immune <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Lupus <input type="checkbox"/> HIV+ <input type="checkbox"/> AIDS <input type="checkbox"/> Other: _____ Patient Name: _____ Date Diagnosed: _____ Treatment: _____ Date Last Treated: _____ Current Status: _____
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"/> Emphysema / Chronic Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other: _____ Patient Name: _____ Date Diagnosed: _____ Treatment: _____ Date Last Treated: _____ Current Status: _____

Eyes/Ears 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"/> Acoustic Neuroma <input type="checkbox"/> Glaucoma Cataracts <input type="checkbox"/> Chronic Ear Infections <input type="checkbox"/> Other: _____ Patient Name: _____ Date Diagnosed: _____ Treatment: _____ Date Last Treated: _____ Current Status: _____																											
Urinary/Kidney <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Renal Failure <input type="checkbox"/> Polycystic Kidney Disease <input type="checkbox"/> Neurogenic Bladder <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Prostate Disorder <input type="checkbox"/> Other: _____ Patient Name: _____ Date Diagnosed: _____ Treatment: _____ Date Last Treated: _____ Current Status: _____																											
Bones/Muscles <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Bulging/Herniated Disc <input type="checkbox"/> Pituitary Dwarfism <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Arthritis (Rheumatoid or Osteo) <input type="checkbox"/> Joint Injury <input type="checkbox"/> Pulled/Strained Muscle <input type="checkbox"/> Other Back/Neck Disorders <input type="checkbox"/> Other: _____ Patient Name: _____ Date Diagnosed: _____ Treatment: _____ Date Last Treated: _____ Current Status: _____																											
Mental Health / Substance Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Bipolar/Manic Depression <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> Alcoholism <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Attention Deficit Disorder <input type="checkbox"/> Other: _____ Patient Name: _____ Date Diagnosed: _____ Treatment: _____ Date Last Treated: _____ Current Status: _____																											
Transplant <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Organ _____ <input type="checkbox"/> Bone Marrow <input type="checkbox"/> Surgery Completed (Date: _____) <input type="checkbox"/> Discussed possible future transplant Patient Name: _____ Current Treatment: _____																											
Medication <input type="checkbox"/> Yes <input type="checkbox"/> No	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:45%;">Member/Dependent Name</th> <th style="width:25%;">Medication</th> <th style="width:15%;">Daily Dosage</th> <th style="width:15%;">Frequency</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>				Member/Dependent Name	Medication	Daily Dosage	Frequency																				
Member/Dependent Name	Medication	Daily Dosage	Frequency																									
Other <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Treatment or surgery 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: _____																											
Tobacco Use <input type="checkbox"/> Yes <input type="checkbox"/> 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 Name: _____ Packs/Day: _____ Years: _____																											
Alcohol Use <input type="checkbox"/> Yes <input type="checkbox"/> No	How frequently do you drink alcohol? _____ Type: _____																											

Please give the name and telephone number of your current doctor(s).

Space for Additional Explanations (If necessary). Please indicate which section you are offering additional explanation for.

G. 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 insurance coverages:

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"/> Medical <input type="checkbox"/> Rx <input type="checkbox"/> Dental
Individual Plan	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Rx <input type="checkbox"/> Dental
Medicaid	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Rx <input type="checkbox"/> Dental
Medicare	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Rx <input type="checkbox"/> Dental

Reason for Medicare eligibility: Age 65 or Over Disabled Kidney Disease Date Eligible: _____
 Type of Medicare Coverage: Part A (Person(s) Covered: _____) Part B (Person(s) Covered : _____) Part D (Person(s) Covered : _____)
 Have you received a Certificate of Creditable Coverage in the last 15 months? Yes No If yes, please attach the certificate to this application.

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.

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

Preferred United Plans
 Administered by SecureOne Benefit Administrators, Inc.
 PO Box 1847
 Grand Rapids, MI 49501-1847
 (616) 235-4459
 (800) 675-1233 Toll Free Claims
 (888) 299-1196 Toll Free Marketing
 insured by:



8220 Irving Road
 Sterling Heights, MI 48312

Your Privacy Is Protected

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

USHL 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 USHL 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 Secure One Administrators, Inc. at 678 Front Avenue NW, Suite 420, Grand Rapids, MI 49504, and this revocation will be effective for future uses and disclosures of protected health information. I further understand, however, that this revocation will not be effective: (i) for information that USHL already has used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition of coverage. (A nonprofit membership organization of life insurance companies that 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.

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. 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.

For Office Use Only	
RECVD _____	MED _____
ENT'D _____	DEN _____
EFF DATE _____	CLASS _____
DIVISION # _____	LIFE _____