

EMPLOYEE HEALTHCARE/LIFE ENROLLMENT FORM



GROUP NAME _____

NOTE: UPON COMPLETION, THIS FORM REPLACES ANY AND ALL PREVIOUS ENROLLMENT FORMS

EMPLOYEE INFORMATION	
EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH
SOCIAL SECURITY NUMBER	
STREET/MAILING ADDRESS	
CITY, STATE, ZIP	SEX
HOME PHONE NUMBER	
MARITAL STATUS: <input type="checkbox"/> -SINGLE <input type="checkbox"/> -MARRIED <input type="checkbox"/> -DIVORCED <input type="checkbox"/> -WIDOWED	DATE OF FULL TIME EMPLOYMENT

COVERAGE REQUEST:	EMPLOYEE/SINGLE	<input type="checkbox"/> -HEALTH	<input type="checkbox"/> -LIFE (IF APPLICABLE)
	SPOUSE	<input type="checkbox"/> -HEALTH	<input type="checkbox"/> -LIFE (IF APPLICABLE)
	CHILDREN	<input type="checkbox"/> -HEALTH	<input type="checkbox"/> -LIFE (IF APPLICABLE)
DECLINATION OF COVERAGE			
I HAVE BEEN GIVEN THE OPPORTUNITY TO PARTICIPATE IN THE GROUP HEALTHCARE PLAN OFFERED BY MY EMPLOYER, AND I DECLINE PARTICIPATION FOR:			
<input type="checkbox"/> MYSELF AND MY ELIGIBLE DEPENDENTS: NAMES: _____			
<input type="checkbox"/> MY ELIGIBLE DEPENDENTS: NAMES: _____			
REASON FOR DECLINING COVERAGE (CHECK ONE):			
<input type="checkbox"/> CURRENTLY COVERED UNDER ANOTHER MEDICAL BENEFIT PLAN			
<input type="checkbox"/> OTHER			
_____ DATE OF SIGNATURE	_____ EMPLOYEE SIGNATURE		

DEPENDENT INFORMATION: PLEASE COMPLETE FOR ALL DEPENDENTS COVERED BY THIS REQUEST					DOES DEPENDENT HAVE OTHER COVERAGE? IF SO, LIST INSURANCE CO. NAME
DEPENDENT NAME (FIRST AND LAST)	SEX M/F	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH MO/DAY/YR	SOCIAL SECURITY #	
SPOUSE					
1.		SPOUSE			
2.					
3.					
(LIST ADDITIONAL CHILDREN ON AN ATTACHED SHEET.) ATTACH COPIES OF LEGAL COURT CUSTODY DECREES OR QUALIFIED MEDICAL CHILD SUPPORT ORDER					
ARE ANY DEPENDENTS AGE 19 AND OVER ATTENDING SCHOOL ON A FULL TIME BASIS? <input type="checkbox"/> -YES <input type="checkbox"/> -NO (A LETTER FROM THE REGISTRAR CONFIRMING FULL TIME STUDENT STATUS MUST BE PROVIDED BEFORE COVERAGE BEGINS.)					
DEPENDENT NAME/SCHOOL			DEPENDENT NAME/SCHOOL		

SPOUSE INFORMATION: COMPLETE ONLY IF REQUESTING COVERAGE FOR SPOUSE.		IS SPOUSE EMPLOYED? <input type="checkbox"/> -YES <input type="checkbox"/> -NO	
SPOUSE'S EMPLOYER (COMPANY NAME)	EMPLOYER ADDRESS (CITY, STATE, ZIP)		
DOES YOUR SPOUSE HAVE GROUP MEDICAL INSURANCE THROUGH HIS/HER EMPLOYER? <input type="checkbox"/> -YES <input type="checkbox"/> -NO			
IF YES, <input type="checkbox"/> -SINGLE <input type="checkbox"/> -FAMILY EFFECTIVE DATE OF COVERAGE: _____			
IS ANY DEPENDENT OR SPOUSE DISABLED? <input type="checkbox"/> -YES <input type="checkbox"/> -NO		DATE DISABILITY BEGAN	TYPE OF DISABILITY
(QUESTION ASKED FOR COORDINATION OF BENEFITS INFO ONLY)			

----- EMPLOYER USE ONLY - PLEASE COMPLETE -----				
<input type="checkbox"/> -NEW EMPLOYEE				
CHANGE: (CHECK ONE) <input type="checkbox"/> -SPECIAL ENROLLEE <input type="checkbox"/> -LATE APPLICANT <input type="checkbox"/> -COBRA <input type="checkbox"/> -RETIREE <input type="checkbox"/> -OTHER				
➤ PLEASE EXPLAIN CHANGE AND DATE OF "QUALIFYING" EVENT AND EMPLOYEE/DEPENDENT NAMES, IF APPLICABLE:				
HIRE DATE	ELIGIBILITY DATE	ORIGINAL EFFECTIVE DATE OF MEDICAL COVERAGE	EFFECTIVE DATE OF CHANGE	EMPLOYER AUTHORIZED SIGNATURE
PRIOR CREDITABLE COVERAGE REQUEST: <input type="checkbox"/> -CERTIFICATE ATTACHED <input type="checkbox"/> -CERTIFICATE TO FOLLOW <input type="checkbox"/> -NO PRIOR CREDITABLE COVERAGE (NO CERTIFICATE)				

**EMPLOYEE: PLEASE CAREFULLY COMPLETE THE MEDICAL QUESTIONS ON PAGE 2
YOUR SIGNATURE IS REQUIRED ON PAGE 4 BEFORE THIS FORM CAN BE PROCESSED!!**

The following questions are to be answered for **EACH PERSON** applying for coverage. Any misstatements may affect your coverage. Give full details to all "Yes" answers in the space provided.

Name: _____ Height _____ Weight _____

1. In the past 5 years, has the person proposed for health coverage been diagnosed, treated by or consulted a licensed physician or practitioner for any of the following:

	YES	NO
a. Abnormal blood pressure, chest pain, stroke, heart attack or murmur or any other heart, blood or circulatory disorder. (IF YES, CURRENT BLOOD PRESSURE _____).....	<input type="checkbox"/>	<input type="checkbox"/>
b. Cancer, tumor, growth, enlarged lymph nodes, skin disorder, or discolored areas or lesions of the skin or mouth	<input type="checkbox"/>	<input type="checkbox"/>
c. Emphysema, lung, or respiratory disorder.....	<input type="checkbox"/>	<input type="checkbox"/>
d. Arthritis, or any disorder of the back or neck, muscles, bones or joints.....	<input type="checkbox"/>	<input type="checkbox"/>
e. Kidney or urinary system disorder, disorder of the prostate or reproductive system, or breast disorder.....	<input type="checkbox"/>	<input type="checkbox"/>
f. Ulcer, colitis, rectal disorder or any disorder of the digestive system, liver or gallbladder.	<input type="checkbox"/>	<input type="checkbox"/>
g. Diabetes, thyroid disorder, speech impairment or disorder of the eyes, ears, nose or throat..	<input type="checkbox"/>	<input type="checkbox"/>
h. Seizures or neurological disorder, mental, nervous or emotional disorder, psychiatric or psychological counseling or treatment.....	<input type="checkbox"/>	<input type="checkbox"/>
2. In the last 5 years, has any person proposed for health coverage:
 - a. Used stimulants, hallucinogens, narcotics or any controlled substance other than as prescribed by a physician?..... YES NO
 - b. Been counseled or treated for use of alcohol or drugs?..... YES NO
3. In the last 5 years, has any person proposed for health coverage been medically treated by a licensed physician or practitioner for Acquired Immune Deficiency Syndrome or AIDS Related Complex (ARC)?..... YES NO
4. In the last 2 years, has any person proposed for health coverage taken prescription medication for more than 30 days? If yes, state condition, name of medication, dosage and frequency in space provided..... YES NO
5. In the last 5 years, has any person proposed for health coverage had any physical disorder, illness, injury, surgery, or check-up, or consultation other than admitted above?..... YES NO
6. Is the person proposed for health coverage currently pregnant? If yes, list due date: _____ YES NO
7. Is the person proposed for health coverage a tobacco user? YES NO
8. Does the person proposed for health coverage exercise 2-3 times per week?..... YES NO

COMPLETE THE FOLLOWING FOR EACH 'YES' ANSWERS TO QUESTIONS 1-8. If additional space is needed, use a separate sheet. Sign, date and return it with this form.

Question No.	Name of Person	Date of Treatment From To	Reason for Check-up Diagnosis, Illness or Condition Frequency of Attacks	Treatment of Findings	Name/Address of each physician and medical facility

9. Does the person proposed for health coverage now carry life or health coverage or have an application pending with another company? If yes, state name of applicant, company, type and amount of coverage and requested effective date in the space below. _____ YES NO
10. Has the person proposed for health coverage had life or health coverage declined, postponed, ridered, rated, canceled or had reinstatement or renewal refused? If yes, state the name of company, action, reason and date in the space below. _____ YES NO

IMPORTANT INFORMATION: PLEASE READ AND SIGN BELOW

HEALTHCARE PRE-EXISTING CONDITION INFORMATION

1. PRE-EXISTING CONDITION LIMITATION (PLEASE READ YOUR HEALTHCARE PLAN BOOK FOR COMPLETE REQUIREMENTS)

IN THE EVENT THAT THE PARTICIPANT OR DEPENDENT COVERED UNDER THIS PLAN RECEIVED MEDICAL ADVICE, DIAGNOSIS, TREATMENT, CARE OR HAD TAKEN OR PURCHASED PRESCRIBED DRUGS IN THE 6 MONTHS PRIOR TO HIS ELIGIBILITY DATE (DEFINED AS THE EARLIER OF THE FIRST DAY OF COVERAGE IN THE PLAN OR THE FIRST DAY OF THE WAITING PERIOD FOR SUCH ENROLLMENT IN THE PLAN), COVERAGE FOR THE CONDITION THAT WAS TREATED SHALL BEGIN AFTER A PERIOD OF 6 CONSECUTIVE MONTHS AFTER THE ELIGIBILITY DATE, (12 MONTHS FOR LATE APPLICANTS) WITH OR WITHOUT MEDICAL TREATMENT FOR THE PRE-EXISTING CONDITION. LATE APPLICANTS (NO QUALIFYING EVENT) WILL BE DENIED ENROLLMENT UNTIL THE NEXT OPEN ENROLLMENT DATE.

THE EXCLUSION OF COVERAGE DUE TO THE ABOVE PRE-EXISTING PROVISION OF THIS PLAN MAY BE REDUCED OR ELIMINATED FOR THOSE PERSONS THAT WERE PREVIOUSLY COVERED BY "CREDITABLE COVERAGE", IF COVERAGE UNDER THIS PLAN BEGINS WITHIN 63 DAYS AFTER DISCONTINUANCE OF COVERAGE UNDER THE OTHER PLAN (NOT INCLUDING ANY WAITING PERIOD). ANY PORTION OF A PRE-EXISTING LIMITATION SATISFIED BY THE PREVIOUS PLAN WILL BE RECOGNIZED BY THIS PLAN.

YOU HAVE THE RIGHT TO DEMONSTRATE CREDITABLE COVERAGE (AND ANY APPLICABLE WAITING PERIODS), BY PRESENTING A CERTIFICATE OF COVERAGE FROM YOUR PREVIOUS GROUP HEALTH OR INDIVIDUAL HEALTH PLANS. THE PARTICIPANT AND/OR DEPENDENT(S) HAVE THE RIGHT TO REQUEST A CERTIFICATE OF COVERAGE FROM A PRIOR PLAN OR ISSUER AND IF NECESSARY, THIS PLAN WILL ASSIST IN OBTAINING A CERTIFICATE FROM A PRIOR PLAN OR ISSUER. **NOTE: CREDITABLE COVERAGE WILL NOT APPLY IF THERE HAS BEEN A GAP IN COVERAGE OF MORE THAN 63 DAYS.**

<input type="checkbox"/> -YES	DID YOU OR ANY OF YOUR DEPENDENTS HAVE GROUP OR INDIVIDUAL MEDICAL COVERAGE WITHIN THE 12 MONTHS PRIOR TO THE EFFECTIVE DATE OF THIS PLAN?
<input type="checkbox"/> -NO	
(IF YES, PLEASE ATTACH YOUR CERTIFICATE OF PRIOR CREDITABLE HEALTH COVERAGE.)	

2. SPECIAL ENROLLMENT PERIOD

IF YOU ARE DECLINING ENROLLMENT FOR YOURSELF OR YOUR DEPENDENTS (INCLUDING YOUR SPOUSE) BECAUSE OF OTHER HEALTH INSURANCE COVERAGE, YOU MAY IN THE FUTURE BE ABLE TO ENROLL YOURSELF OR YOUR DEPENDENTS IN THIS PLAN, PROVIDED THAT YOU REQUEST ENROLLMENT WITHIN 31 DAYS AFTER YOU LOSE YOUR OTHER COVERAGE.

IN ADDITION, IF YOU HAVE A NEW DEPENDENT AS A RESULT OF MARRIAGE, BIRTH, ADOPTION, OR PLACEMENT FOR ADOPTION, YOU MAY BE ABLE TO ENROLL YOURSELF AND YOUR DEPENDENTS, PROVIDED THAT YOU REQUEST ENROLLMENT WITHIN 31 DAYS AFTER THE MARRIAGE, BIRTH, ADOPTION OR PLACEMENT FOR ADOPTION. DETAILS OF SPECIAL ENROLLMENT PROVISIONS CAN BE REVIEWED IN THE EMPLOYEE BENEFIT PLAN BOOK.

IMPORTANT: THIS FORM MUST BE COMPLETED AND ON FILE WITH YOUR EMPLOYER OR THE SPECIAL ENROLLMENT PERIOD DESCRIBED ABOVE WILL NOT APPLY.

LIFE INSURANCE BENEFICIARY DESIGNATION LIST YOUR PRIMARY AND CONTINGENT (2 ND CHOICE) BENEFICIARIES HERE. IF YOU LIST MORE THAN ONE PRIMARY OR CONTINGENT BENEFICIARY, YOUR BENEFIT WILL BE DIVIDED EQUALLY AMONG THE SURVIVING BENEFICIARIES UNLESS YOU INDICATE OTHERWISE. YOU MAY CHANGE YOUR BENEFICIARY AT ANY TIME. (IF BENEFICIARY IS A TRUST, GIVE COMPLETE NAME OF TRUST AND TRUSTEE.)	
<u>PRIMARY BENEFICIARY NAME(S) AND RELATIONSHIP TO YOU</u>	<u>CONTINGENT BENEFICIARY NAME(S) AND RELATIONSHIP TO YOU</u>

ASSIGNMENT AND AUTHORIZATION

ASSIGNMENT: I HEREBY AUTHORIZE PAYMENTS DIRECTLY TO THE PROVIDER OF SERVICE BY MY EMPLOYER'S HEALTHCARE PLAN HEREIN NAMED OF THE GROUP BENEFIT'S PAYABLE TO ME. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS ASSIGNMENT.

AUTHORIZATION: I HEREBY AUTHORIZE RELEASE, TO OR BY FIRST ADMINISTRATORS, INC., OF ANY HOSPITAL, MEDICAL, OR OTHER INSURANCE INFORMATION CONCERNING MYSELF OR ANY OF MY DEPENDENTS WHICH MAY BE REQUIRED TO PROCESS MY CLAIM. A PHOTOCOPY OF THIS AUTHORIZATION MAY BE HONORED. I HEREBY REQUEST THE AMOUNT(S) AND FORMS FOR COVERAGE FOR WHICH I AM OR MAY BECOME ELIGIBLE, AND HEREBY AUTHORIZE MY EMPLOYER TO DEDUCT THE REQUIRED CONTRIBUTION, IF ANY, FROM MY EARNINGS.

I AUTHORIZE ANY PHYSICIAN, MEDICAL PRACTITIONER, HOSPITAL, CLINIC, OTHER MEDICAL OR MEDICALLY RELATED FACILITY, INSURANCE OR REINSURING COMPANY, MEDICAL INFORMATION BUREAU, CONSUMER REPORTING AGENCY, EMPLOYER, OR THE VETERANS ADMINISTRATION, HAVING INFORMATION AVAILABLE AS TO ADVICE, DIAGNOSIS, TREATMENT, OR CARE OF ANY PHYSICAL OR MENTAL CONDITION CONCERNING ME, MY SPOUSE, OR MY MINOR CHILDREN, INCLUDING INFORMATION ABOUT DRUGS, ALCOHOLISM, OR MENTAL ILLNESS, AND ANY OTHER NON-MEDICAL INFORMATION CONCERNING ME, MY SPOUSE, OR MY MINOR CHILDREN TO GIVE TO HAGAN INSURANCE GROUP, ITS AFFILIATES, ITS LEGAL REPRESENTATIVE, OR ITS REINSURERS ANY AND ALL SUCH INFORMATION.

I UNDERSTAND AND AGREE THAT THE STATEMENTS AND ANSWERS IN THIS APPLICATION ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF AND SHALL FORM A PART OF THE CONTRACT OF HEALTH COVERAGE. I ALSO UNDERSTAND AND AGREE THE HEALTH COVERAGE APPLIED FOR, IF ISSUED, SHALL BE SUBJECT TO SUCH STATEMENTS AND ANSWERS AND WILL TAKE EFFECT ON THE EFFECTIVE OF THIS HEALTH COVERAGE PROVIDED THE PREMIUM HAS BEEN PAID.

I UNDERSTAND THE INFORMATION OBTAINED BY USE OF THE AUTHORIZATION WILL BE USED BY HAGAN INSURANCE GROUP OR IT'S AFFILIATES TO DETERMINE ELIGIBILITY FOR HEALTH COVERAGE.

I AGREE THAT A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

I AGREE THAT THIS AUTHORIZATION SHALL REMAIN VALID FOR TWO YEARS FROM THE DATE SHOWN BELOW.

I HAVE READ AND COMPLETED ALL OF THE INFORMATION OUTLINED ABOVE

EMPLOYEE SIGNATURE

DATE SIGNED