Employee Enrollment Form/Stop Loss Underwriting Questionnaire

❑ New group
❑ Addition to existing group
Group # ___________________________

Employer Name: ____ Requested effective date: ________/________/__________

Coverage Description:
Your employer is considering self-funding its employee benefit plan to provide health coverage to its employees with stop loss insurance protection to control its risk. Your completion of this enrollment form is necessary for your employer's application for this coverage.

Enrollment Form Instructions:
—If you and all eligible dependents are enrolling for medical coverage, complete all sections of the enrollment form except D, Request to Waive Coverage. Be sure to sign and date at the bottom of section H.
—If you and all dependents are waiving/declining coverage, complete sections A, B and D. Be sure to sign and date at the bottom of section D.
—If you are enrolling for coverage but have eligible dependents waiving, complete all sections of the enrollment form.

A. Employee Information

Last name	First name	MI	Gender ❑ Male ❑ Female	Marital status ❑ Single ❑ Married
Social Security Number	Date of birth	Height	Weight	Tobacco use in last 12 months ❑ Yes ❑ No
Home address	City	State	ZIP code	
Telephone number—best number to reach you	This number is for my ❑ work ❑ home ❑ mobile	Best time to call __________________ ❑ a.m. ❑ p.m.		
Email address	Date of full-time employment	Hours worked per week		
Job title/occupation	Location/Department			
How would you like to receive your Explanation of Benefits? ❑ Email **only** ❑ U.S. mail	Compensation basis ❑ Salary ❑ Hourly ❑ Commission	Employee status ❑ W2 ❑ 1099 ❑ Owner/partner	Current status ❑ Actively at work ❑ Continuation or COBRA - termination date: ____________________ ❑ Other (such as leave of absence, disability, etc.) ____________________	

B. Application Intentions

Coverage Type	Enrolling for coverage for:			Waiving coverage for:		
	Myself/Employee	Spouse	Child(ren)	Myself/Employee	Spouse	Child(ren)
Medical	❑	❑	❑	❑	❑	❑
Dental	❑	❑	❑	❑	❑	❑

Administrative Use Only	Timely EE	Spec Enroll	Late Enroll	24-hour cov	Life Amount	PCEFDT	Pre-Ex Ends	Eff Date	UW Apprvl	Part #	Entered by

C. Spouse and Dependent Children Information—only those ENROLLING for coverage

Spouse last name	Spouse first name	Spouse MI	Gender	Tobacco use in last 12 months
			❑ Male ❑ Female	❑ Yes ❑ No

Social Security Number	Date of birth	Height	Weight

Child(ren) name (last, first, MI)	Date of birth	Gender	Height	Weight	Relationship	Social Security Number
		❑ M ❑ F			❑ Child ❑ Stepchild ❑ Adopted ❑ Other	
		❑ M ❑ F			❑ Child ❑ Stepchild ❑ Adopted ❑ Other	
		❑ M ❑ F			❑ Child ❑ Stepchild ❑ Adopted ❑ Other	
		❑ M ❑ F			❑ Child ❑ Stepchild ❑ Adopted ❑ Other	

D. Request to Waive Coverage

I, and/or my dependents, request to decline coverage because of:

	Other group coverage	Individual medical	Government-sponsored plan (other than Medicare)	Medicare	COBRA	Other	No coverage
Employee	❑	❑	❑	❑	❑	❑	❑
Spouse	❑	❑	❑	❑	❑	❑	❑
Child(ren)	❑	❑	❑	❑	❑	❑	❑

***If "Other group coverage" or "Medicare" were selected, provide details below under "*Other insurance information."**

Spouse Information—if waiving coverage

Spouse name (last, first, MI)

Dependent Child(ren) Information—if waiving coverage

Child name (last, first, MI)	Child name (last, first, MI)
Child name (last, first, MI)	Child name (last, first, MI)

Other Insurance Information

Is coverage for any individual listed above required due to court order, divorce decree or paternity suit? ❑ Yes ❑ No

If "Yes," please attach a copy of the section of the court order or divorce decree pertaining to health insurance coverage, unless previously provided to the Appointed Self-Funded Administrator and the information is still current.

If waiving due to other **group insurance coverage**, provide the following information about the group policy:

Name of policyholder	Policyholder's date of birth	Policy number

Employer's name	Employer's address	City	State	ZIP code

Insurance company name	Insurance company telephone number	Family members covered by group insurance

If waiving due to other **Medicare coverage**, provide the following information:

Family members covered by Medicare	Medicare ID number

Medicare eligibility due to: ❑ Age 65+ ❑ Kidney failure ❑ Disability	Medicare Part A effective date / /	Medicare Part B effective date / /

This is to acknowledge I have been given the opportunity to apply for the coverages available to me and my dependents (if any) and have elected not to enroll myself or my dependents (if any). I understand that by applying for coverage at a later date, a dependent of mine or I may be considered a late applicant. I acknowledge that I have not been persuaded to waive coverage by my employer or the broker.

I understand that if I waive coverage for myself or my dependents because of being covered under other health insurance coverage, I may, in the future, be able to enroll myself or my dependents in this plan if the other health insurance coverage terminates. The other health coverages must have terminated because of either: 1)the "loss of eligibility" for coverage, or 2) the termination of the employer plan by the employer. I understand that I must apply for coverage within 30 days of a qualifying life event or termination of other coverage to be eligible for a special enrollment period. "Loss of eligibility" includes a loss of coverage due to legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment. Loss of eligibility does not include an individual's failure to pay premiums on a timely basis or in the event of termination of coverage for cause. Examples of a loss of coverage for cause include the making of a fraudulent claim or an intentional misrepresentation of fact in connection with a group health plan.

In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I understand I may be able to enroll myself and certain dependents, provided that I apply within 30 days after the marriage, birth, adoption, or placement for adoption.

X ____ ____________________

Signature of employee *(if declining coverage)* Date

E. Stop Loss Underwriting—Health Questions

The information gathered here will not be used to determine employee or dependent eligibility for coverage under the employer's health benefit plan, or in any other discriminatory fashion. The information will be used only by the stop-loss underwriter to assess and rate its risk.
Please provide complete details to any question marked "Yes" in the appropriate space provided in section E. We may need to request additional information regarding your health history from you and/or your attending physician.

1. Are you or your enrolling dependents currently taking or have been prescribed medications within the past 12 months? *If yes, complete the medications chart below.* ❑ Yes ❑ No

Person's name	Medication/condition	Frequency and dosage	Length of time on medication?	Complete names and addresses of physicians

2. Does any person to be insured currently have, or had within the past five years symptoms, diagnosis, consultation, treatment, or taken any medication or received counseling for any disorder or disease of the following: (*Remember to provide details to any "Yes" answers in Section F - Health History Details)*

Circulatory System	a. Abnormal heart beat/palpitations, blood disorder/hemophilia, hypertension, chest pain, heart disease/murmur/heart attack or coronary artery disease, lymphadenopathy/immune disorder, stroke, vascular disease	❑ Yes ❑ No
	b. High blood pressure, high cholesterol or high triglycerides *(If yes, please provide the most recent readings and date)* Blood pressure reading: _______/_______ Cholesterol reading: _______________ Triglyceride reading: ___________________ Date : ____________________________ Date: __________________________ Date: ______________________________	❑ Yes ❑ No
Cyst, Polyp, Tumor	c. Cancer, tumors/cysts/polyps/growths	❑ Yes ❑ No
Endocrine Disorders	d. Diabetes/pancreatic disorders, thyroid, goiter Last A1C Rating: ___________ Date:___________	❑ Yes ❑ No
Gastrointestinal Disorders	e. Colitis, hepatic, spastic colon, polyps, digestive disorder/reflux, gallbladder disorder, hernia, ulcerative colitis, Chron's/regional ileitis, ulcers, Hepatitis (A, B, or C), liver disorder	❑ Yes ❑ No

Genitourinary Disorders	f. Abnormal Pap smear, breast disorder, infertility testing/treatment, menstrual disorder, reproductive organ disorder, endometriosis, sexually transmitted diseases, Acquired Immune Deficiency Syndrome (AIDS), bladder disorder, kidney disorder, prostate/rectal disorder	❑ Yes ❑ No
	g. Current pregnancy *If yes, please provide the expected due date*______________________________	❑ Yes ❑ No
Nervous Disorders	h. Anorexia/bulimia, mental, nervous, emotional disorder/anxiety, depression/attention deficit disorder, mental retardation/ Down syndrome, neurological disease, sleep disorders	❑ Yes ❑ No
	i. Epilepsy and/or seizure, headaches/migraines, muscular dystrophy, cerebral palsy, neurological disease, paralysis	❑ Yes ❑ No
Other Disorders	j. Abnormal tests results, alcoholism/alcohol abuse, drug addiction, ear/throat disorders, eye disorders, transplants	❑ Yes ❑ No
Respiratory Disorders	k. Allergies, asthma/respiratory disorder, cystic fibrosis, emphysema/lung disorder, sleep apnea, sinus disorder, tuberculosis If "yes" for sleep apnea and treatment is through a CPAP machine, do you rent or own the machine? ❑ Rent ❑ Own	❑ Yes ❑ No
Skeletal/ Muscular Disorders	l. Arthritis, back/muscle/joint disorder, bone disease/deformity, congenital disorder, fracture/dislocation, Lupus/systemic or discoid, rheumatism, skin disorder, spinal disorder, back/neck strain	❑ Yes ❑ No

3. Are you or any enrolling dependents receiving treatment for or have you been advised of a condition that will require medical attention or medical test(s)?	❑ Yes ❑ No
4. Are you or any enrolling dependents currently disabled, or confined to a hospital, medical facility or your home due to a medical condition or disability?	❑ Yes ❑ No
5. Have you or any enrolling dependents incurred medical expenses over $10,000 in the last 12 months?	❑ Yes ❑ No

F. Health History Details, *(details required for "Yes" answers above).* This information will only be used by the stop-loss underwriter to assess and rate the risk.

Ques. #	Person's name	Condition and treatment	Date of onset Mo/Yr	Recovery date Mo/Yr	Complete name and address of physicians and hospitals

G. Prior Insurance Coverage Information

1. Have you and all dependents enrolling been covered by this employer's **major medical** plan for the past 12 months?	❑ Yes ❑ No
2. Have you and all dependents enrolling been covered under a **major medical** plan with another carrier(s) other than your current employer coverage within the past 12 months? *If "Yes", attach a copy of the certification of group health insurance plan coverage or other documentation of creditable coverage* ***AND*** *complete the following:*	❑ Yes ❑ No

Name(s) of covered family member	Effective date	Termination date (if applicable)	*Type of Coverage*					
			Employer group coverage	Individual medical	Government-sponsored plan	COBRA	Medicare	Other
			❑	❑	❑	❑	❑	❑
			❑	❑	❑	❑	❑	❑

Is coverage for any individual listed above required due to court order, divorce decree or paternity suit? ❑ Yes ❑ No
If "Yes," please attach a copy of the section of the court order or divorce decree pertaining to health insurance coverage, unless previously provided to the Appointed Self-Funded Administrator and the information is still current.

If prior insurance coverage is **group insurance** that is not this employer's current plan, provide the following information about the group policy:

Name of policyholder	Policyholder's date of birth	Policy number		
Employer's name	Employer's address	City	State	ZIP code
Insurance company name	Insurance company telephone number	Family members covered by group insurance		

If prior insurance coverage is **Medicare**, provide the following information:

Family members covered by Medicare	Medicare ID number	
Medicare eligibility due to: ❑ Age 65+ ❑ Kidney failure ❑ Disability	Medicare Part A effective date / /	Medicare Part B effective date / /

H. Agreement and Signature

Premium Payment: I authorize my employer to deduct the requested premium contribution, if any, from my earnings.

Full-Time Employment: I understand that one of the requirements for eligibility on the effective date and for continued eligibility under the plan is that I am actively at work and employed full-time (at least 30 hours per week or a different full-time work schedule as determined by the employer) at my employer's place of business.

Pre-Certification: I understand that failure to comply with the requirements to pre-certify or provide notification of treatments, as may be required by my employer's Summary Plan Description may result in reduced benefits pursuant to the terms of the Summary Plan Description.

Authorization to Release Information: I hereby authorize any physician or medical practitioner, hospital, or other organization, institution or person that has any medical information or knowledge of me or my family as to diagnosis, treatment and prognosis regarding any physical, mental, drug or alcohol condition or any and all such information to be given to Appointed Self Funded Administrator, my employer's health plan administrator, or any organization performing business or legal services in connection with my enrollment form or claim, including but not limited to pre-certification of hospital admissions, continued stay review, on-site concurrent review (where applicable) or as may be otherwise lawfully required or as I further authorize. (Photocopy of this authorization shall be valid as the original and is valid for 30 months from the date shown below.)

U.S. Resident: I understand that the coverage under this plan is available for United States residents and benefits are not payable for medical expenses outside of the United States except for Emergency Care when traveling.

My answers are true and correct: I have personally reviewed all of my answers to the questions on this enrollment form and represent that all of the information I have provided is true and complete. I understand that it is my responsibility to provide truthful, complete and accurate information and I represent I have fully understood all questions asked. I understand that under no circumstances is any agent allowed to (a) waive, alter or modify any questions; (b) permit me to inaccurately answer any questions; or instruct me not to disclose any particular medical condition on the enrollment form. I understand that no agent is authorized or has authority to alter the terms of the Summary Plan Description.

Application for coverage: I understand that my coverage will not be inforce until my employer's enrollment form for stop loss insurance is approved in accordance with the underwriting guidelines in effect.

X ____ ____________________

Signature of employee *(and parent if applicant is under age 18)* Date