

TO BE COMPLETED BY GROUP (for new or enrolling employee)	
Company Name/DBA:	Company Address:

You must complete this form in its entirety in order for you or your dependents to be covered under the health insurance plan. If you are waiving coverage for yourself or your dependents, it must be clearly indicated on this form. If you do not complete this form in its entirety for yourself or your dependents at least 5 business days prior to the effective date, you or your dependents may not be eligible for coverage until the next open enrollment period.

TO BE COMPLETED BY EMPLOYEE (if applying or waiving coverage)	
BENEFIT PLAN:	GROUP NUMBER:

A - EMPLOYEE (Primary Applicant)				
Name (Last, First, MI):				
Social Security Number:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date (mm/dd/yyyy):	Average number of hours worked per week?	Date of Full-Time Employment: (mm/dd/yyyy)
Home Street Address (other than P.O. Box)		City	State	Zip
Home Phone:		Work Phone:	Email Address:	
Cell Phone:		Best Time to Call:	Occupation:	
Status: <input type="checkbox"/> Single <input type="checkbox"/> Married		Check One: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA <input type="checkbox"/> Cal-COBRA COBRA effective date(mm/dd/yyyy) _____		Earnings Basis: <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly <input type="checkbox"/> Commission
Employee Status: <input type="checkbox"/> W2 <input type="checkbox"/> 1099 <input type="checkbox"/> Owner/Partner				

NEW ENROLLMENT or WAIVER, please check one:	
<input type="checkbox"/> New Hire	<input type="checkbox"/> Qualifying Life Event: _____ Date: (mm/dd/yyyy) _____
<input type="checkbox"/> Re-hire	<input type="checkbox"/> COBRA
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Waiver of Coverage (complete section B)
<input type="checkbox"/> New Group	<input type="checkbox"/> Other: _____

B - WAIVER OF COVERAGE	
Complete and sign if waiving any or all coverages for self. Skip if enrolling for coverage. All eligible employees must be listed as either enrolling or waiving coverage when first eligible.	

Indicate the waiver reason below.				
<input type="checkbox"/> Individual Medical	<input type="checkbox"/> Medicare/Medicaid	<input type="checkbox"/> COBRA/Continuation	<input type="checkbox"/> Tricare	<input type="checkbox"/> Spouse's Employer
<input type="checkbox"/> Cost/Do not want <input type="checkbox"/> Other: _____				

Neither I nor my dependents have been induced or pressured to decline coverage by my employer, the agent, or National Health Insurance Company. I and my dependents have waived such coverage of our own accord.

Signature:	Date:
Printed Name:	Date of Full-time Employment:

C – ONLY TO BE COMPLETED BY ADDITIONS TO EXISTING GROUPS OR FOR CHANGES TO EXISTING COVERAGE

Requested effective date: / / (Subject to Underwriting approval)

1. Groups with multiple medical plans, indicate which plan you are requesting.* Medical Plan #:

**Please contact your employer for the plan options/descriptions which are identified on your employer's billing statement and/or quote.*

2. If enrolling outside of your employer's open enrollment period, indicate the reason (documentation may be required)

- a) Marriage Birth Adoption Court ordered (copy of court order required)

For any event in a, list date of event / /

- b) Divorce/Separation Involuntary loss of coverage, state reason for loss COBRA/Continuation exhausted
 Other

For any event in b, list coverage termination date / /

D – PERSONS TO BE COVERED

(Include yourself and all family members to be insured. If more space is needed, attach an additional sheet.)

<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee Spouse	<input type="checkbox"/> Employee Children	<input type="checkbox"/> Family: Employee, Spouse, & Children	
Include yourself & all family members to be insured Last Name	First Name	Relationship & Gender	Date of Birth (MM/DD/YYYY)	Social Security Number
		Employee <input type="checkbox"/> M <input type="checkbox"/> F	XXXXXX	XXXXXX
		Spouse <input type="checkbox"/> M <input type="checkbox"/> F		
		Child <input type="checkbox"/> M <input type="checkbox"/> F		
		Child <input type="checkbox"/> M <input type="checkbox"/> F		
		Child <input type="checkbox"/> M <input type="checkbox"/> F		
		Child <input type="checkbox"/> M <input type="checkbox"/> F		

E – ADDITIONAL INSURANCE COVERAGE INFORMATION

1. Will any current medical plan remain active if coverage is approved?	<input type="checkbox"/> Yes <input type="checkbox"/> No
a) If "Yes", for whom?	
b) Please provide carrier and ID/Group number	
2. Are you, your spouse or any dependent children currently covered under Medicare Part A, B, or D?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, will coverage remain active if the coverage for which you are applying is approved?	<input type="checkbox"/> Yes <input type="checkbox"/> No

F – MEDICAL HISTORY			
	Height	Weight	Used any form of tobacco/nicotine in the last 12 months?
Employee			<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse			<input type="checkbox"/> Yes <input type="checkbox"/> No

1. Have you or any of your dependents included on this enrollment form within the past 5 years received treatment, testing, consulted with or received a diagnosis from a physician or provider for any of the following (**check all that apply**). Provide details to yes answers and all conditions checked on the following page in section G.

- | | |
|---|---|
| <input type="checkbox"/> AIDS or HIV
<input type="checkbox"/> Alcohol or Drug Use, Abuse, or Dependency
<input type="checkbox"/> Arthritis or other Skeletal Disorder
<input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid
<input type="checkbox"/> Other
<input type="checkbox"/> Back Disorders
<input type="checkbox"/> Chiro <input type="checkbox"/> Sprain/strain
<input type="checkbox"/> Surgery <input type="checkbox"/> Other
<input type="checkbox"/> Blood Disorders (including anemia)
<input type="checkbox"/> Cancer or Tumor; Stage _____
<input type="checkbox"/> Local (confined to the organ where it began)
<input type="checkbox"/> Regional (spread to nearby lymph nodes/organs)
<input type="checkbox"/> Distant/Metastasis (spread to distant organs)
<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Diabetes Mellitus Date of onset ____/____/____
<input type="checkbox"/> Pre-Diabetes <input type="checkbox"/> Diet Controlled
<input type="checkbox"/> Type I <input type="checkbox"/> Type II
<input type="checkbox"/> Insulin Dependent <input type="checkbox"/> Insulin Pump
<input type="checkbox"/> Diabetic Related Disorders
<input type="checkbox"/> Heart disease <input type="checkbox"/> Nephropathy
<input type="checkbox"/> Neuropathy <input type="checkbox"/> Peripheral Vascular Disease
<input type="checkbox"/> Retinopathy <input type="checkbox"/> Stroke
<input type="checkbox"/> Digestive Disorders
<input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Ulcerative Colitis
<input type="checkbox"/> Other
<input type="checkbox"/> Ear/Eye/Nose/Throat Disorders
<input type="checkbox"/> Endocrine Disorders
<input type="checkbox"/> Fracture/Broken Bone
<input type="checkbox"/> Heart Disorders
<input type="checkbox"/> Angioplasty <input type="checkbox"/> Bypass
<input type="checkbox"/> Heart Attack <input type="checkbox"/> Other
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Hodgkin's/Lymphoma/Leukemia
<input type="checkbox"/> Immune Disorders | <input type="checkbox"/> Infertility
<input type="checkbox"/> Kidney Disorders
<input type="checkbox"/> Knee Injury or Disorder
<input type="checkbox"/> Liver Disorder/Hepatitis
<input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C
<input type="checkbox"/> Hepatitis D <input type="checkbox"/> Other
<input type="checkbox"/> Lupus
<input type="checkbox"/> Discoid
<input type="checkbox"/> Systemic Lupus Erythematosus
<input type="checkbox"/> Mental, Nervous or Behavioral Disorder
<input type="checkbox"/> Inpatient Treatment <input type="checkbox"/> Outpatient Treatment
<input type="checkbox"/> ADHD/ADD <input type="checkbox"/> Anxiety
<input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Depression
<input type="checkbox"/> Other
<input type="checkbox"/> Migraine or Chronic Headache
<input type="checkbox"/> Multiple Sclerosis (MS)
<input type="checkbox"/> Muscle Disorders
<input type="checkbox"/> Nervous System Disorders
<input type="checkbox"/> Paralysis
<input type="checkbox"/> Partial or Total Disability
<input type="checkbox"/> Physical Disorder or Deformity
<input type="checkbox"/> Reproductive Disorders
<input type="checkbox"/> Respiratory/Lung Disorders
<input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Bronchitis
<input type="checkbox"/> COPD <input type="checkbox"/> Other
<input type="checkbox"/> Seizures
<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Stroke or Transient Ischemic Attack
<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism
<input type="checkbox"/> Growth Disorder <input type="checkbox"/> Other
<input type="checkbox"/> Transplant
<input type="checkbox"/> Solid Organ <input type="checkbox"/> Blood or Marrow
<input type="checkbox"/> Urinary Disorders
<input type="checkbox"/> Vascular Disorders |
|---|---|

2. In the last 5 years, have you or any of your dependents included on this enrollment form:
- a. Been diagnosed with or treated for any condition(s) not identified above? Yes No
- b. Been advised of the necessity or possibility of any future hospitalization, treatment, testing or surgery?... Yes No
3. Are you or any of your dependents included on this enrollment form currently pregnant? Yes No
- a. If yes, Indicate due date ____/____/____
- b. Is a Cesarean Section anticipated? Yes No
- c. Are multiple births expected? Yes No
- d. Are you/your dependent experiencing or anticipating any other complications?..... Yes No
4. Have medications been prescribed in the past 18 months for you and/or any dependents included on this enrollment form. (Include pills, creams, injections, liquids, inhalers, pumps, etc.) Yes No

G – DETAILS

Please provide FULL DETAILS to any yes/checked answers in section F; including the name of the Applicant(s), condition(s), treatment(s), medication(s), and dates. If more space is needed please attach a separate page with details; include the Employee's name.

Question	Person	Condition/Diagnosis	Dates Treated	Treatment including Medications and Dosage	Date Last Taken	Prognosis

H – *** NOTICE OF FEDERAL MANDATES ***** INITIAL NOTICE ABOUT SPECIAL ENROLLMENT RIGHTS*******

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your, or your dependents', other coverage).

You must, however, request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the 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.

Effective April 1, 2009 a federal mandate took effect that allows for a Special Enrollment Period, which is outlined below.

A Special Enrollment Period will be provided for an employee and his/her dependent(s) who are eligible, but not enrolled, for coverage under the terms of our plan to enroll for coverage if either of the following conditions are met:

- a) The employee or dependent is covered under a Medicaid plan or under a State child health plan and coverage of the employee or dependent under that plan is terminated as a result of loss of eligibility for coverage. The request for coverage under our group health plan must be submitted no later than 60 days following the date of termination of such prior coverage under Medicaid or a State child health plan.
- b) The employee or dependent becomes eligible for assistance under a Medicaid plan or under a State child health. The request for coverage under our group health plan must be submitted no later than 60 days following the date of the employee or dependent is determined to be eligible for such assistance.

I – APPLICATION Authorization, Signature, and Health Plan Arbitration Agreement:

I hereby represent that I am an employee of the participating employer and that the statements and answers to the questions on this enrollment form are true and complete to the best of my knowledge and belief. I understand that the statements and answers contained herein will be used by National General Benefits Solutions to determine eligibility for coverage under the Self- Funded Program (“Program”) for myself and persons listed on this enrollment form as my spouse or dependent children.

When applicable, I authorize my employer to deduct contributions from my earnings to be applied to the cost of coverage.

I understand that (1) the answers given will be the basis of any coverage provided; (2) any material misrepresentation or failure to provide complete information to questions on this enrollment form may be used as a basis for changing rates or terminating coverage. (3) if coverage is not approved, I, my spouse and/or dependent children are not entitled to benefits;(4) if I, my spouse and/or dependent children waive coverage and decide to apply for coverage at a later date, evidence of eligibility may be required and benefits may be deferred for a specified period of time; and (5) coverage will not be effective until I receive notice that this enrollment form has been approved by National General Benefits Solutions.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, pharmacy or pharmacy-related entity, pharmacy benefits manager (PBM) or PBM-related entity, consumer reporting agency, insurance or reinsurance company or employer, having information about me or my minor children to provide all such information as may be requested to National General Benefits Solutions, its legal representative or any medical records retrieval service National General Benefits Solutions may engage, including, but not limited to EMSI.

This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, lab data and EKGs. This information may also be disclosed to any medical records company engaged by National General Benefits Solutions, including but not limited to EMSI and its agents. Although federal regulation requires that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by National General Benefits Solutions pursuant to this authorization will be protected by federal and state privacy laws and regulations.

I understand that this authorization is required in order to enable National General Benefits Solutions to make eligibility or enrollment determinations relating to me and/or my dependents or for National General Benefits Solutions underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, National General Benefits Solutions may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying National General Benefits Solutions in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, National General Insurance Company, 2200 Highway 121, 2nd Floor, Bedford, TX 76021. Such revocation will not be valid if National General Benefits Solutions has taken action in reliance on the authorization.

This authorization expires upon the earliest of the following events: denial of my application, declination of enrollment, or, if covered, when I am no longer covered under this Program, but in no event will this authorization be in effect for longer than 24 months from date signed.

Any person who knowingly and with intent to defraud any insurance company or other person submits an enrollment form for coverage or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I acknowledge that I have been advised that (1) fraudulent statements or misrepresentation of material facts may result in retroactive termination of your coverage and (2) knowing and willful misstatements in this individual health questionnaire may represent a criminal violation of 18 US Code Section 1347 (punishable by up to 10 years in prison).

Employee/Primary Applicant Signature: _____ Date: _____