Employee Enrollment Form/ Waiver of Coverage/ Underwriting Form

❑ **Enrollmen**t:
Group # _____
Plan Name/Option _____
❑ **Waiver of Coverage**

Employer Name: _____ Requested Effective Date: _____

Coverage Description:

Your employer is considering self-funding its employee benefit Plan to provide health coverage for its employees and purchasing Stop-Loss insurance protection to control the employer's risk. Your completion of this Enrollment Form in its entirety is necessary for your enrollment in your employer's benefit Plan and for your employer's application for the Stop-Loss insurance coverage.

If any of the information on this Enrollment Form is incomplete or the Enrollment Form is not received within 30 days following the first day an individual is eligible for coverage, the individual will not be enrolled in the employer's health benefit Plan and they must wait until the next eligibility date to be covered. Eligibility for coverage is defined as: a) New Hire: first day of the month following date of hire plus a waiting period; b) Special Enrollment Event; c) first day of the Open Enrollment Period.

Whether to enroll or not enroll an individual under the Plan is solely the decision and responsibility of the employer; the Stop-Loss insurer does not participate in, or have any authority to determine, the employer's Plan eligibility requirements and enrollment of individuals.

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, Agreement and Signature.
- If you and all dependents are waiving/declining coverage, complete sections A, C 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	Marital Status
			❑ Male ❑ Female	❑ 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	Best time to call
	❑ work ❑ home ❑ mobile	_____ ❑ a.m. ❑ p.m.

Email Address	Date of Full-Time Employment	Hours worked per week
		❑ 30 or more ❑ Less than 30

Job Title/Occupation	Location/Department

Compensation Basis	Employee Status	Current Status
❑ Salary ❑ Hourly ❑ Commission	❑ W2 ❑ 1099 ❑ Owner/Partner	❑ Actively at Work ❑ Continuation or COBRA – Termination Date: _____ ❑ Other (such as leave of absence, disability, etc.) _____

B. 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	
		❑ M ❑ F			❑ Child ❑ Stepchild ❑ Adopted ❑ Other	
		❑ M ❑ F			❑ Child ❑ Stepchild ❑ Adopted ❑ Other	

C. Application Intentions

Coverage Type	Enrolling for Coverage for:			Waiving Coverage for:		
	Myself/Employee	Spouse	Child(ren)	Myself/Employee	Spouse	Child(ren)
Medical	☐	☐	☐	☐	☐	☐

If you or your dependents are enrolling due to Special Enrollment (qualifying events), state the reason and date of the event:

Qualifying Event:	Date of Event:

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)	☐	☐	☐	☐	☐	☐	☐
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 and be subject to postponement of insurance coverage until I am eligible to apply during my company's **Open Enrollment Period,** unless eligible to enroll for coverage during the **Special Enrollment Period** following a qualifying event described below. 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, during the **Special Enrollment Period**, if the other health insurance coverage terminates. The other health coverage 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 following a qualifying 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, during the **Special Enrollment Period**, provided that I apply within 30 days after the date of the marriage, birth, adoption, or placement for adoption.

If I do not request enrollment during the **Special Enrollment Period**, or provide a fully completed Enrollment Form, within 30 days following the date of the occurrence of one of the above events, I understand that I may not be able to enroll for coverage until my company's next **Open Enrollment Period**.

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 insurer's underwriter to assess and rate its risk.
Please provide complete details to any question marked "Yes" in the appropriate space provided in section F. It is important that you truthfully and honestly answer the questions and provide complete details about your health history and the health history of your dependents. Any material misrepresentations or failure to provide full disclosure may result in the Stop-Loss insurer adjusting the rates for your employer's Stop-loss Insurance policy. This could result in your employer being required to pay more premium, which in turn, may affect any premium contributions you may be required to pay for your coverage under your employer's health benefit Plan. **Whether to enroll or not enroll an individual under the Plan is solely the decision and responsibility of the employer; the Stop-Loss insurer does not participate in, or have any authority to determine, the employer's Plan eligibility requirements and enrollment of individuals.**

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?

2. Does any person to be insured currently have, or had within the <u>past five years</u> 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. If extra space is needed to record additional readings for other enrollees, please provide the readings in Section F.)* 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 *(If extra space is needed to record additional ratings for other enrollees, please provide the ratings in Section F.)* 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 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 home residence 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

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," 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

By signing below I acknowledge and confirm the following:

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

2. **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.

3. **Pre-certification:** I understand that failure to comply with the requirements to pre-certify or provide prior 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.

4. **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.

5. **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 for myself and any dependents enrolling for coverage and I represent I have fully understood all questions asked. **I understand that any material misrepresentations or failure to provide full disclosure may result in the Stop-Loss insurer adjusting my employer's Stop-Loss insurance rates. Any decision not to enroll an individual under the Plan is solely the decision and responsibility of the employer, not the Stop-Loss insurer; the Stop-Loss insurer does not participate in, or have any authority to determine, the employer's Plan eligibility requirements and enrollment of individuals.** I further 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 employer's Summary Plan Description.

6. **Authorization for Release of Health-Related Information**.
   I authorize the disclosure of my health information:

Print Name: **(Last)**	**(First)**	**(MI)**	**(Month/Day/Year)**	**Social Security Number**

I authorize the disclosure of any and all information that: (i) is created or received by a health care provider, health plan including health insurer or health insurance agent, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (ii) relates to my past, present, or future physical or mental health or condition; the provision of health care; or the past, present, or future payment for the provision of health care. This authorization permits the disclosure of all my medical records including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, and prescription drug information.

I specifically authorize the disclosure of information related to (i) communicable diseases, including HIV, AIDS or AIDS related complex (to the extent permitted by both state and federal law); (ii) drug and alcohol abuse and treatment; (iii) mental illness and treatment; and (iv) genetic conditions including genetic testing (to the extent permitted by both state and federal law). Notwithstanding the above, this authorization does not authorize the release of psychotherapy notes.

I authorize any and all health care providers including without limitation physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, pharmacy benefit managers, pharmacies or pharmacy-related facilities; and any and all health plans, insurance companies, insurance support organizations (such as MIB Group), business associates of health plans or insurance companies and those persons or entities providing services to such business associates to disclose the information described above.

I authorize Westport Insurance Corporation ("WIC"), including its affiliated companies and subsidiaries to receive the disclosure of information authorized herein and use the information disclosed pursuant to this authorization.

The purpose of the disclosure authorized herein is to permit WIC, including its affiliated companies and subsidiaries to obtain and use the information described above to make prospective and retrospective underwriting and risk rating determinations.

This authorization shall expire twenty-four (24) months after the date on which it is executed below.

I understand that my execution of this authorization is for the use or disclosure of the information described above for the purpose of making underwriting and risk rating determinations. Except as otherwise stated herein, treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on an authorization for the use or disclosure of the information described above.

I understand that I may revoke this authorization by sending written notice of my intent to revoke this authorization to: 5200 Metcalf Avenue, P.O. Box 2991, Overland Park, KS 66201-1391, Attention Privacy Officer.

I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

A copy or facsimile of this authorization shall be as valid as the original.

X _____ _____

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