ASSURANT Health®

ASSURANT® SELF-FUNDED HEALTH PLANS
EMPLOYEE ENROLLMENT FORM

Instructions for completing this enrollment form

1) Each eligible employee enrolling for any coverage offered must complete the entire enrollment form except **Section B**. Section B must be completed only if enrolling in an existing plan or making changes to an existing plan.
2) Any eligible employee waiving all coverages offered, only needs to complete and sign the Waiver of Coverage in **Section F**.
3) This enrollment form must be completed in ink.
4) If your employer offers multiple medical plans, please review the options with your employer.

Name of Employer: _____

Your Work Address: _____

SECTION A -- EMPLOYEE INFORMATION

Employee's Name: _____
Last *First* *MI*

Employee's Mailing Address: _____
Street *City* *State* *Zip*

Home Phone: (_____) _____ Best Time to Call: a.m. p.m. Work Phone: (_____)_____ Best Time to Call: a.m. p.m.

E-mail Address: _____ Are you a U.S. Citizen? ☐ Yes ☐ No Are you a legal resident? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married (Date of Legal Marriage:_____) ☐ Divorced (Date of Legal Divorce: _____)

Full-time Employment Date: _____/ _____ / _____ Occupation/Job Duties: _____

Hours worked per week for this employer: _____ Monthly Earnings: $_____

Current Status: ☐ Currently Working ☐ COBRA ☐ Continuation ☐ Disability ☐ Retired ☐ Other Leave _____

Earnings Basis: ☐ Salaried ☐ Hourly ☐ Commission **Employee Status:** ☐ W2 ☐ 1099 ☐ Owner/Partner ☐ Other *(specify)*: _____

Effective Date of COBRA/Continuation or Other Leave *(MM/DD/YYYY)*: _____ / _____ / _____

SECTION B (Only to be completed by additions to existing groups or for changes to existing coverage.)

Group #: _____ Requested effective date: ____/____/____ (Subject to Underwriting approval)

This enrollment is for *(check one)*: ☐ New Enrollee ☐ Coverage Change *(specify)* ☐ Adding Spouse ☐ Adding Dependent Coverage

☐ Other Change *(specify type):*_____ *# of Children:* _____

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.*

SECTION C -- PERSONS TO BE COVERED
(Include yourself and all family members to be insured. If more space is needed, attach an additional sheet.)

☐ None ☐ Single: Employee only ☐ Employee & Spouse ☐ Employee & Children ☐ Family: Employee, Spouse & Children

(Include yourself and all family members to be insured) **Last Name** **First Name**	**Relationship & Gender**	**Date of Birth (Mo/Day/Yr)**	**Social Security Number**
	Employee ☐ Male ☐ Female	/ /	– –
	Spouse ☐ Male ☐ Female	/ /	– –
	Child ☐ Male ☐ Female	/ /	– –
	Child ☐ Male ☐ Female	/ /	– –
	Child ☐ Male ☐ Female	/ /	– –
	Child ☐ Male ☐ Female	/ /	– –
	Child ☐ Male ☐ Female	/ /	– –

Please explain if any child listed above is (a) not your natural child, legally adopted child or stepchild, (b) not solely supported by you, or (c) not permanently residing in your household. _____

Stop loss insurance for self-funded plans is provided by Time Insurance Company.

SECTION D – MEDICAL HISTORY

	Height	Weight	Used any form of tobacco/nicotine in the last 12 months?
Employee			☐ Yes ☐ No
Spouse			☐ Yes ☐ No

1. List all medications prescribed in the past 18 months for you and any dependents included on this enrollment form. (Include pills, creams, injections, liquids, inhalers, pumps, etc.)

(Complete all columns. If more space is needed, attach an additional sheet of paper which must be signed and dated.)

Individual *(Full Name)*	Name of Medication	Dosage & Frequency of Use	Date Prescribed	Date Last Used	Condition(s) Being Used For

For all "YES" answers to the following questions, provide full details in SECTION E on next page.

2. Have you or any of your dependents included on this enrollment form within the past *10 years* been diagnosed with or treated for any of the following ***(If "Yes", circle all that apply)*****:** ..... ☐ Yes ☐ No
   Cancer/Tumor; Chest Pain; Respiratory/Lung Disorders; Heart Attack/Bypass/Angioplasty; Heart Disorders; Vascular Disorders; Systemic Lupus Erythematosus; Hodgkin's/Lymphoma/Leukemia; Blood Disorders; Immune Disorders; Liver Disorder/Hepatitis; Multiple Sclerosis (MS); Stroke; or Tested Positive or Been Treated for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), Sexually Transmitted Diseases?
3. Have you or any of your dependents included on this enrollment form within the past *5 years* been diagnosed with or treated for any of the following ***(If "Yes", circle all that apply)*****:** ..... ☐ Yes ☐ No
   Asthma; Back Disorders; Muscle Disorders; Osteoarthritis, Rheumatoid or other Arthritis; Skeletal Disorders; Crohn's Disease; Ulcerative Colitis; Digestive Disorders; Urinary Disorders; Kidney Disorders; Seizures; Paralysis; Nervous System Disorders; Ear/Eye/Nose/Throat Disorders; Reproductive Disorders; Endocrine Disorders; any Other Physical Disorder or Deformity or a Partial or Total Disability?
4. Have you or any of your dependents included on this enrollment form:
   a. Within the past *5 years*, been confined in a hospital, residential treatment center, mental health, or medical facility, or had outpatient surgery or had medical expenses in excess of $3,000 in any one year or been absent from work, school, confined to home or incapacitated for more than 2 consecutive weeks due to illness or injury?..... ☐ Yes ☐ No
   b. In the past *18 months*, been seen by any health care provider for emergency services, routine follow-up or ongoing medical care; received consultation, treatment, therapy, advice or undergone any testing?..... ☐ Yes ☐ No
   c. Been advised of the necessity or possibility of any future hospitalization, treatment, testing or surgery?..... ☐ Yes ☐ No
   d. Been receiving Workers' Compensation?..... ☐ Yes ☐ No

   If "Yes", provide name and telephone number of claims processor. _____
5. Have you or any of your dependents included on this enrollment form received any treatment, including but not limited to counseling for alcoholism, or chemical, alcohol or drug abuse or addiction, used illegal drugs or prescription medication other than as prescribed, been advised by a physician to discontinue or decrease alcohol consumption or drug use? ..... ☐ Yes ☐ No
6. Have you or any of your dependents included on this enrollment form been treated for the following conditions, and if "Yes", provide the following information:
   a. Hypertension/High Blood Pressure ..... ☐ **Yes** ☐ **No**

   If "Yes", list last 3 blood pressure readings: Applicant Name _____ Current ___ 6 mo ___ 1 yr ___

   Additional Applicant Name _____ Current ___ 6 mo ___ 1 yr ___

   b. Diabetes Mellitus (type): ☐ **Type 1 Juvenile Diabetes** ☐ **Type 2 Adult Onset Diabetes** ..... ☐ **Yes** ☐ **No**

   If "Yes", check treatment: ☐ Diet Controlled ☐ Oral Medications ☐ Insulin ☐ Insulin Pump

   Date of onset: _____ /_____ /_____

   Include your last Hemoglobin A1c Reading and Date: _____ _____/_____/_____

   c. Diabetic Related Disorders ***(If "Yes", circle all that apply)***..... ☐ **Yes** ☐ **No**

   Heart Disease, Stroke, Kidney Impairments (Nephropathy), Visual Impairments (Retinopathy), Peripheral Vascular Disease, Nerve Impairments such as Numbness or Burning of Legs or Feet (Neuropathy)

   d. Mental, Nervous or Behavioral Disorders ..... ☐ **Yes** ☐ **No**

   Diagnosis: _____

   Treatment ***(If "Yes", circle all that apply)*****:**
   Inpatient Treatment, Outpatient Treatment, Counseling, Prescription Medication(s)
7. Are you or any dependents included on this enrollment form currently pregnant, an expectant parent, in the process of adoption, undergoing or have undergone infertility treatment? ..... ☐ Yes ☐ No

   And state If yes, Due Date: _____ /_____ /_____ Date of Adoption: _____ /_____ /_____

   Are you anticipating complications for you or your unborn child and/or multiple births? ..... ☐ Yes ☐ No

   Are you anticipating a cesarean section? ..... ☐ Yes ☐ No

SECTION E -- MEDICAL HISTORY DETAILS (Details for all answers marked "YES" must be provided below.)

(Complete all columns. If more space is needed, attach an additional sheet of paper which must be signed and dated.)

Question # and Letter	Individual *(Full Name)*	Diagnosis and/or Condition	Dates of Diagnosis and/or Condition	Explain Treatment Include any Hospitalization, Tests or Surgery	Results/Degree of Recovery and Current Status	Physician/ Specialty/ Hospital Telephone Number

SECTION F -- WAIVER OF COVERAGE (Complete and sign if waiving any or all coverages for self and/or dependents.)

All eligible employees and dependents must be listed as either enrolling or waiving coverage when first eligible. If you or any of your eligible dependents do not enroll in Time Insurance Company medical coverage when it is first made available and want to enroll in the future, your coverage may be subject to an extended pre-existing period exclusion. This pre-existing exclusion does not apply to maternity benefits. For further information on the late addition policy for group employers in your state, please contact your agent or a Time Insurance Company representative.

Person(s) Waiving	Carrier name(s)	ID No.(s)	Effective Date(s)
☐ **Employee**			
☐ **Spouse**			
☐ **Child(ren)**			

Indicate the type of coverage in effect and for whom.

Type of Coverage	For Whom?		
☐ **Spouse's Employer Plan**	☐ Employee	☐ Spouse	☐ Child(ren)
☐ **Medicare / Medicaid**	☐ Employee	☐ Spouse	☐ Child(ren)
☐ **Tricare**	☐ Employee	☐ Spouse	☐ Child(ren)
☐ **COBRA**	☐ Employee	☐ Spouse	☐ Child(ren)
☐ **Individual**	☐ Employee	☐ Spouse	☐ Child(ren)
☐ **Other, explain:**	☐ Employee	☐ Spouse	☐ Child(ren)

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

Signature: _____ **Date of Signature:** _____

Printed Name: _____ **Date of Full-time Employment:** _____

SECTION G -- PRIOR INSURANCE COVERAGE INFORMATION

(Failure to supply complete information may result in a pre-existing condition limitation.)

1. Have you and all dependents you are enrolling been covered by this employer's major medical plan(s) for the past 12 months? ☐ Yes ☐ No
2. Have you, your spouse or dependent children been covered by any type of medical plan within the last 18 months? ☐ Yes ☐ No

If "Yes", list all plans in effect during the past 18 months.

Covered Persons	Insurance Company Name and Policy #	Effective Date (MM/DD/YYYY)	Termination Date (MM/DD/YYYY)	Reason for Termination
☐ Employee ☐ Spouse ☐ Child				
☐ Employee ☐ Spouse ☐ Child				

Will any current medical plan remain active if coverage is approved? ☐ Yes ☐ No

If "Yes", for whom? _____

3. Are you, your spouse or any dependent children covered currently covered under Medicare Part A, B, or D? ☐ Yes ☐ No

   If yes, will coverage remain active if the coverage for which you are applying is approved? ☐ Yes ☐ No

SECTION H -- AUTHORIZATION AND SIGNATURE (Required if enrolling for any coverages for self and/or dependents.)

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 Time Insurance Company to determine eligibility for coverage under the Assurant® Self-Funded Health Plans ("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 thtat (1) the answers given will be the basis of any coverage provided; (2) coverage, if approved, may be subject to limitations regarding pre-existing conditions as defined by the Summary Plan Description; (3) 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 my coverage; (4) if coverage is not approved, I, my spouse and/or dependent children are not entitled to benefits; (5) 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 (6) coverage will not be effective until I receive notice that this enrollment form has been approved by Time Insurance Company.

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 Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company 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 Time Insurance Company, 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 Time Insurance Company 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 Time Insurance Company to make eligibility or enrollment determinations relating to me and/or my dependents or for Time Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Assurant Health, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization. I understand that Assurant Health markets products underwritten and issued by Time Insurance Company and that all references to Time Insurance Company in this authorization also include Assurant Health.

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 understand that the agent submitting this enrollment form represents my interests, not those of Time Insurance Company. The agent has no right to bind coverage, to alter the terms of coverage or enrollment form in any manner, or to adjust any claim for benefits. I, or my personal representative, have a right to receive a copy of this enrollment form.

Signature of Employee _____ **Date** _____

PLEASE NOTE: 1) Time Insurance Company is not responsible for enrollment forms not sent to us in a timely manner. 2) Effective dates are subject to underwriting approval. 3) Please retain a copy for your records.

********** NOTICE **********

IMPORTANT INFORMATION FOR APPLICANT AND ELIGIBLE DEPENDENTS REGARDING THE PRE-EXISTING CONDITION LIMITATION

This plan contains a pre-existing conditions limitation. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before we will provide coverage for that condition.

This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. If you are in a waiting period for coverage, however, the six-month period ends on the day before the waiting period begins.

The preexisting conditions limitation does not apply to pregnancy, or to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

The exclusion may last up to 18 months if you are a late enrollee from your first day of coverage, or from the first day of your waiting period (if you are in a waiting period). You may, however, be eligible to reduce the length of this exclusion period by the number of days of any prior "creditable coverage." Most prior health coverage is creditable coverage, and can be used to reduce the preexisting conditions limitation if you have not experienced a break in coverage of at least 63 days or more. Otherwise, you and/or dependent(s) will be subject to the full preexisting conditions limitation period.

To reduce the limitation period using your creditable coverage, you should give us a copy of any certificate(s) of creditable coverage you have. If you had prior health coverage, but you do not have a certificate of creditable coverage, you have a right to request one from your prior plan or issuer; or, if necessary, we can help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about preexisting conditions limitations and creditable coverage should be directed to Allied Benefit Systems' Customer Service Department at 200 West Adams, Suite 500, Chicago, IL 60606.

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.

To request special enrollment, or to obtain more information, please contact Allied Benefit Systems' Customer Service Department at 1-888-292-0272.