AMERICAN ADVANTAGE HEALTH PLAN

Application for: ☐ **New Coverage**
☐ **Adding a dependent**
☐ **Group #** ______________

PPO Network: ___________________________

EMPLOYEE ENROLLMENT FORM

Form MUST BE Completed in Ink

EMPLOYER / PLAN SPONSOR	DATE OF HIRE	SALARY	HOURS WORKED PER WEEK

EMPLOYEE'S NAME (LAST)	FIRST	INITIAL	MAIDEN	EMPLOYEE'S OCCUPATION

SEX	DATE OF BIRTH	AGE	**HEIGHT** Ft. In.	**WEIGHT** Lbs.	MARITAL STATUS	SOCIAL SECURITY NUMBER

EMPLOYEE'S HOME ADDRESS			**TELEPHONE NUMBERS** HOME: **( )** WORK: **( )**
CITY	STATE	ZIP	ARE YOU AND YOUR DEPENDENTS U.S. CITIZENS? ☐ YES ☐NO
EMPLOYEE'S EMAIL ADDRESS			IS YOUR SPOUSE EMPLOYED? ☐ YES ☐NO

SCHEDULE OF FAMILY MEMBERS TO BE COVERED (IF NEEDED, ATTACH ADDITIONAL SHEET, SIGNED AND DATED BY THE EMPLOYEE)

Please PRINT Full Name	Sex	Relationship to Employee	Date of Birth	Age	Height Ft. In.	Weight Lbs.	Social Security Number
1.		**Spouse**					
2.		**Child**					
3.		**Child**					
4.		**Child**					

PLAN INFORMATION

TYPE OF COVERAGE (check one)	PRIMARY INSURED'S LIFE INSURANCE BENEFICIARY DESIGNATION
☐ Medical and Life Insurance	BENEFICIARY NAME: ______________________
☐ Life Insurance Only	RELATIONSHIP TO PRIMARY INSURED: ______________

Privacy Policy Statement

This privacy policy statement is provided by Advanced Insurance Administration, a contract third party administrator of the group health benefit plan, and is intended to provide a clear explanation of our privacy policies as they relate to members of the benefit plan. We may collect information about you from the following sources:

- The application for coverage in the benefit plan;
- Sponsors of prior insurance programs;
- Medical management companies;
- Your medical providers;
- Your medical plan claims examiners;
- Disclosures by your employer or Plan Administrator;
- Agents / Brokers that have worked to place the group insurance program.

We may disclose any or all of the information that we collect from the sources described above.
We may disclose personal information about you or your family members (if they are benefit plan participants) to:

- Your employer;
- Your medical plan's designated medical management company and claims examiners;
- Your group plan administrator;
- Any insurance companies that may insure your benefit plan;
- Others that may have a financial interest in your benefit plan.

If you prefer that we not disclose personal information about you or your family members (if they are benefit plan participants), you may opt out of our disclosure programs other than those disclosures permitted by law. If you desire to opt out, please call 800-234-5453 between 8:30 AM and 4:30 PM Central Standard Time, ask for customer service and request an opt out form. If you opt out, we will restrict disclosure of personal information to only those permitted by law to access such information. Your signature indicates your authorization to disclosure of personal information to the persons or entitles noted for a period of 24 months from your signature date. You may revoke this authorization, at any time, by providing written notice to Advanced Insurance Administration.

OTHER HEALTH COVERAGE

	YES	NO
1. Within the last 6 months, has any person to be covered: a) had any hospital, medical or major medical insurance?	☐	☐
b) applied for such insurance?	☐	☐
2. Will the coverage being applied for replace existing insurance?	☐	☐
3. How many months have you or your dependents been insured without any lapse in coverage? ___________________		
4. Within the last 5 years, has any person to be covered been declined for life or medical insurance?	☐	☐
5. Has any person to be covered been treated for or diagnosed with cancer?	☐	☐

(If question 4 or 5 above is answered "YES," **provide details below. Please provide a copy of the Certificate of Credible Coverage for all applicable participants.**

Name of Insured ____ Policy / Certificate #___________________________________

Name of Insurance Company _____________________________ Name(s) of Covered Person(s) _________________________

Effective Date ____ Termination Date_____________________________________

HEALTH HISTORY QUESTIONNAIRE

All of the following questions must be answered in ink in the employee's own handwriting for each person applying for coverage. Use a separate sheet, if necessary; sign, date and attach answers to the questionnaire. If any "YES" answers related to heart conditions, chest pain/pressure, diabetes, high blood pressure (hypertension), stroke, circulatory problems, crohn's, diverticulitis, regional enteritis, or ileitis, colitis, cancer, tumor, polyp, neurological conditions, epilepsy, paralysis or seizures are present, the supplemental HEALTH HISTORY QUESTIONNAIRE on the next page. (pg. 3) must be completed before the application can be reviewed.

FAILURE TO REVEAL COMPLETE MEDICAL INFORMATION ON ALL PERSON'S SEEKING COVERAGE, WHETHER INTENTIONAL OR UNINTENTIONAL, MAY RESULT IN CLAIM DENIAL.

	YES	NO
1. **In the last five years has anyone:**		
a) Suspected an illness, been to or consulted a doctor, psychiatrist, therapist, medical practitioner or health care provider for any symptoms or disorders?	☐	☐
b) Had any surgery, hospitalization, observation room stay, or hospital emergency room treatment or minor emergency room clinic, urgent care clinic or outpatient treatment?	☐	☐
c) Been diagnosed, treated for, consulted by a doctor or suspected of having any of the following? **(Please check all that apply):** ☐ aids, HIV, aids related complex (ARC), disorder of the blood, immune or lymph system ☐ alcoholism, mental, emotional or nervous disorders (i.e. depression) ☐ cancer, tumors or polyp (benign or malignant) ☐ diabetes ☐ chest pain/pressure or heart condition ☐ high blood pressure, stroke, or other circulatory problems ☐ liver or gallbladder problems, hepatitis or cirrhosis ☐ digestive problems, ulcers, hernia or colitis ☐ kidney, urinary, tract or prostate problems ☐ reproductive, menstrual, or breast disorder ☐ respiratory or lung problems, bronchitis, asthma, emphysema, or pneumonia ☐ neurological conditions, epilepsy, paralysis or seizures ☐ skeletal or muscular condition, back, knee or neck pain ☐ crohn's, diverticulitis, colitis, regional enteritis or ileitis ☐ physical or mental birth defect, developmental, behavioral or physical impairment condition, disorder or symptom		
d) Been disabled?	☐	☐
e) Had a work related illness or injury?	☐	☐
2. Have you or any dependent, within the last 12 months, incurred more than $5,000 in medical expenses?	☐	☐
3. **a)** Are you, or is any family member currently pregnant or an expectant parent? (including adoption)	☐	☐
b) Provide due date or expectant placement date: ____		
4. Are you or any dependent using tobacco products or nicotine products?	☐	☐
5. **a)** Is anyone currently taking any prescribed medicines, drugs, pills, or shots? (include daily as well as medication only taken when needed)? If yes, please list below all medications and the conditions each is intended to treat.	☐	☐
b) Has anyone been prescribed a medication that they are not taking?	☐	☐
6. **a)** Has anyone been told of a need or possible need for, or is anyone planning or scheduled for future treatment, medical testing or examination (i.e. physical therapy, specialist consultation, surgery, hospitalization, medical treatment)?	☐	☐
b) Are there any symptoms present for which anyone will be seeking treatment?	☐	☐

Quest. #	Person's Name	Nature of Medical Advice or Treatment, Diagnosis, Medications, Date of Treatment, Duration of condition	Degree of recovery, Results of Treatment, Prognosis	Name, phone number and addresses of Physicians & Hospitals

HEALTH HISTORY QUESTIONNAIRE

USE DARK INK ONLY. ANSWERS MUST BE COMPLETED IN YOUR OWN HANDWRITING.

1. Heart Conditions, Chest Pain/Pressure ______________________________________

Name of applicant or dependent with condition)

a. Check all that apply: ☐ Heart Attack ☐ Myocardial Infarction ☐ Angina ☐ Coronary Bypass ☐ Coronary Angioplasty ☐ Irregular Heart Beat ☐ Arrhythmias ☐ Atrial Fibrillation or Flutter ☐ PVCs (premature ventricular contracts) ☐ Heart Murmur ☐ Mitral Valve Prolapse ☐ Heart Valve Replacement / Surgery ☐ Transplant ☐ Congenital Heart Abnormality

b. Date of onset ____Date of recovery ____________________________________

c. Was surgery performed? ________ List all surgeries: type and date? ____

d. List all heart medication and dosages: ____

2. Diabetes ______________________________________

(Name of applicant or dependent with condition)

a. Date of onset ____________________________________Current blood sugar level and date __________________________

b. Number of units of insulin _________________ Name of oral medication and dosage _________________________________

c. Any hospitalizations required? ☐YES ☐NO. If so, indicate the dates and reason ___________________________________

____

d. Any eye, kidney, circulatory problems or complications? ☐Yes ☐NO If YES, how often?_______________

e Do you monitor your blood sugar levels? ☐Yes ☐NO If YES, how often?_______________

f. Do you have a home glucose-monitoring device? ☐Yes ☐NO

g. How often are you examined by your physician? ____________________

3. High Blood Pressure (Hypertension), Stroke, Circulatory Problems

____

(Name of applicant or dependent with condition)

a. Age when first diagnosed ____________________________Year when treatment began ______________________________

b. Is medication being taken? ☐YES ☐NO. If YES, Name _________________________Dosage ____________________

c. Any hospitalizations required? ☐YES ☐NO. If so, indicate the dates and reason ___________________________________

____

d. Please indicate the dates and the results of the last three blood pressure readings taken by either you ☐ or your doctor ☐.
Date ______________________ Reading ___________________ Date ___________________ Reading __________________
Date ______________________ Reading ___________________

e. Please indicate the date and results of your electrocardiogram (EKG) or stress test (if none, state "none") ___________________

____

4. Crohn's Disease, Diverticulitis, Regional Enteritis or Ileitis, Colitis

____

(Name of applicant or dependent with condition)

a. Type ____ Date of last attack or episode? ___________________

b. Date first diagnosed ___________________________ Number of attacks in the past 12 months __________________________

c. Surgically corrected? ☐YES ☐NO. If YES give year, procedure, and the outcome _________________________________

____

d. Is Medication being taken? ☐ YES ☐ NO. If YES, Name ___________________________ Dosage __________________

e. Other complications or medical impairments? Specify, details: ____

5. Cancer, Tumor, or Polyp

____

(Name of applicant or dependent with condition)

a. Give type and location ____ ☐ Malignant? or ☐ Benign?

b. Date diagnosed ____________________ Surgically removed? ☐YES ☐ NO. If YES, give date _______________________

c. Did you receive radiation therapy?___________ If yes, how many treatments?___________ Date of last treatment__________

d. Did you receive chemotherapy?_____________ If yes, how many treatments?___________ Date of last treatment__________

e. Any recurrence? ☐YES ☐NO. If YES, give date of treatment and results ____

f. Was there any lymph node involvement? ☐YES ☐NO

g. Any metastasis? ☐YES ☐NO

h. Current Treatment? ____

6. Neurological Conditions, Epilepsy, Paralysis or Seizures

____

(Name of applicant or dependant with condition)

a. Type ____Date of last episode ____________________________

b. Number of episodes per year ______________________Year in which condition diagnosed ____________________________

c. Is medication currently being taken? ☐YES ☐NO. If YES, Name ______________________Dosage __________________

d. Date of last hospitalization or surgery? ____

e. Date first diagnosed ____

f. Cause of Seizure Disorder ____

I hereby certify that the above information is correct and wholly true to the best of my knowledge and belief.

EMPLOYEE'S REPRESENTATION AND AUTHORIZATION

Knowingly, and with intent to defraud any insurance company, submitting an application for insurance or a statement of claim containing any materially false or incomplete information or concealing information concerning any fact material thereto for the purpose of misleading is a crime, which may be subject to criminal and civil penalties. Claims are subject to denial for non-disclosed medical conditions.

WAIVER OF PARTICIPATION

Each eligible employee who chooses not to apply for coverage for self, spouse, or dependent children must complete this section.

I voluntarily waive ☐ Life Insurance ☐ Medical Insurance

For (check all that apply): ☐ Myself ☐ My eligible spouse ☐ My eligible spouse and dependent children ☐ My eligible dependent children

Reason for waiving coverage: ☐ Coverage under another plan ☐ Coverage under spouse's plan

Indicate type of other coverage: ☐ Individual ☐ Group ☐ Medicare ☐ Other (Explain) :____

☐ Cobra Date Cobra Coverage began ____ / _____ / _____

I hereby certify that I have been offered the opportunity to participate in my employers sponsored health plan. The benefits which are available have been thoroughly explained to me. I understand that if I wish to apply for coverage at a later date, I must furnish proof of insurability before I can become insured. As a late entrant, I understand that coverage may be postponed or subject to pre-existing condition limitations as permitted by law.

____ ____

Employee Signature **Date**

AUTHORIZATION TO RELEASE RECORDS OR MEDICAL INFORMATION

By signing below, I represent that I have read the completed application form, together with any application supplement, and that all my answers and statements recorded therein are correct, complete, and wholly true to the best of my knowledge and belief. I understand that my qualification for insurance is based upon my answers and statements. I understand: 1) that this form seeks full disclosure of the information sought and no one has the authority to alter or exclude or to direct me to exclude any qualification information sought by this form; 2) that incorrect or incomplete disclosure of any such qualification information may result in loss of coverage or claim denial; 3) that medical benefits for pre-existing conditions may be limited; 4) that only eligible family members listed on this application may become insured, and any future additions to coverage must complete a new application.

I also understand that medical benefits will be reduced or denied for failure to follow the procedures for pre-certification, certification for certain medical services and "continued stay" review, where applicable. In the event of my death while insured, any death benefit payable under the coverage issued through Cosmopolitan Life Insurance shall be paid pursuant to the beneficiary designation indicated on this application, or then in effect. I authorize deductions from my earnings of any contributions, as may be required now or later for continued participation. I understand and agree that the insurance applied for shall not become effective until issued by the Company and the initial premium (including applicable fees) is paid in full. In no event will the effective date of the insurance be earlier than 10 days after the date of this application.

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, the Medical Information Bureau, Inc. (MIB, Inc.), consumer reporting agency, my current agent and general agent, insurance or reinsuring company, or employer having certain information about me, my spouse or my children to give to **Advanced Insurance Administration** or **Physicians Medical Review** any and all such information. The nature of the information authorized to be disclosed includes information about: (1) physical condition(s); (2) health history(ies), medical records and/or x-ray films; (3) avocation(s); (4) age(s); (5) occupation(s); and (6) personal characteristics. FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" AND "X-RAY" FILMS SHALL INCLUDE ALL CONFIDENTIAL INFORMATION RELATED TO: HIV, COMMUNICABLE DISEASES, ALCOHOL OR DRUG ABUSE, AND MENTAL HEALTH DIAGNOSIS/TREATMENT

I UNDERSTAND that this Authorization will be valid for one year from the date below, and that the information released under this Authorization will be used by Employers Choice Health Plan to determine eligibility for insurance and benefits. I ALSO AUTHORIZE **Advanced Insurance Administration** to release any information obtained to reinsuring companies, Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize potential for re-disclosure: information used or disclosed pursuant to this authorization may be subject to re-disclosure by recipient and thus may no longer be protected under privacy rules and regulations. I AM AWARE that I may request a copy of this Authorization. I AGREE that a copy of the Authorization shall be as valid as the original. To revoke authorization, I can contact the HIPAA Privacy Office, Advanced Insurance Administration, 1525 Merrill Drive Suite 2000, Little Rock, AR 72211 501-312-4666.

X____ Date: _______________/____________/_______________

Signature of Proposed Insured Employee Month Day Year

SIGNED AT: ____

City State Zip Code