



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			
CITY						STATE	ZIP		HOME: ()
EMPLOYEE'S EMAIL ADDRESS						WORK: ()			
						ARE YOU AND YOUR DEPENDENTS U.S. CITIZENS?			
						<input type="checkbox"/> YES <input type="checkbox"/> NO			
						IS YOUR SPOUSE EMPLOYED?			
						<input type="checkbox"/> YES <input type="checkbox"/> 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) <input type="checkbox"/> Medical and Life Insurance <input type="checkbox"/> Life Insurance Only	PRIMARY INSURED'S LIFE INSURANCE BENEFICIARY DESIGNATION BENEFICIARY NAME: _____ 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 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 entities 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Will the coverage being applied for replace existing insurance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. How many months have you or your dependents been insured without any lapse in coverage? _____ | | |
| 4. Within the last 10 years, has any person to be covered been declined for life or medical insurance | <input type="checkbox"/> | <input type="checkbox"/> |

(If either question 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 employees applying for coverage must answer the following questions and **PROVIDE DETAILS TO "YES" ANSWERS BELOW**. 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, please complete the supplemental HEALTH HISTORY QUESTIONNAIRE on the next page. (pg. 3).

		YES	NO
1. In the last ten 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Had any surgery, hospitalization, observation room stay, or hospital emergency room treatment or minor emergency room clinic, urgent care clinic or outpatient treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Been diagnosed, treated for, consulted by a doctor or suspected of having any of the following? (Please check all that apply): <input type="checkbox"/> aids, HIV, aids related complex (ARC), disorder of the blood, immune or lymph system <input type="checkbox"/> alcoholism, mental, emotional or nervous disorders (i.e. depression) <input type="checkbox"/> cancer, tumors or polyp (benign or malignant) <input type="checkbox"/> diabetes <input type="checkbox"/> chest pain/pressure or heart condition <input type="checkbox"/> high blood pressure, stroke, or other circulatory problems <input type="checkbox"/> liver or gallbladder problems, hepatitis or cirrhosis <input type="checkbox"/> digestive problems, ulcers, hernia or colitis <input type="checkbox"/> kidney, urinary, tract or prostate problems <input type="checkbox"/> reproductive, menstrual, or breast disorder <input type="checkbox"/> respiratory or lung problems, bronchitis, asthma, emphysema, or pneumonia <input type="checkbox"/> neurological conditions, epilepsy, paralysis or seizures <input type="checkbox"/> skeletal or muscular condition, back, knee or neck pain <input type="checkbox"/> crohn's, diverticulitis, colitis, regional enteritis or ileitis <input type="checkbox"/> physical or mental birth defect, developmental, behavioral or physical impairment condition, disorder or symptom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Been disabled?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Had a work related illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you or any dependent, within the last 12 months, incurred more than \$5,000 in medical expenses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you or any dependent using tobacco products or nicotine products?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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, 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
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