US HEALTH AND LIFE INSURANCE COMPANY
8220 Irving Road • Sterling Heights, MI 48312
1-800-211-1538 • www.ushealthandlife.com

Employee Enrollment Form

A. Employer Information
To be completed by employer

☐ Initial Group Enrollment ☐New Hire ☐Rehire (within 6 months) ☐Status Change ☐Reapply After Waiver ☐Open Enrollment
☐ Other: _____ Effective Date: _____ If Status Change, what is the reason for the change (i.e. COBRA)?: _____
Group (Employer) Name: _____ Division:_____
Date of Hire (MM/DD/YY): _____ Class:___ Salary: _____ Initials: _____

B. Employee Information
This section must be completed

Coverage Selection: ☐ Medical Coverage ☐ Employee Life & Employee AD&D*
☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced Date of Marriage or Divorce: _____
Name: _____ Name Change ☐
(First) (M.I.) (Last)
Address: _____ Address Change ☐
City: _____ State: _____ Zip: _____
Date of Birth: _____ Social Security Number: _____ Occupation: _____
Daytime Phone Number: _____ Height: _____ Weight: _____
Life Insurance: Beneficiary Name:_____ Relationship:_____ Beneficiary Change ☐
Is this person COBRA eligible? ☐Yes ☐ No If yes, qualifying event date:_____ Beginning of COBRA coverage:

C. Waiver
This section must be completed if declining to enroll

I decline to enroll in Medical coverage for ☐myself ☐my spouse and/or ☐my dependent children due to:
☐Spousal coverage ☐ Existence of other health coverage ☐ Other reason (explain): _____

I decline to enroll in Life and AD&D coverage* for ☐myself ☐ my spouse and/or ☐ my dependent children due to:
☐Spousal coverage ☐ Existence of other health coverage ☐ Other reason (explain): _____

*(*Life and AD&D may not be offered by your employer. AD&D not available for dependents. Dependent Life may not be offered by your employer) Check the applicable boxes, then read and sign.*

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage will be subject to treatment as a late enrollee and I may only apply at the next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 31 days after such other health coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependent, provided that I request enrollment within 31 days after such marriage, birth, adoption or placement for adoption. Further, if I waive Life and AD&D coverage at this time and choose to enroll at a later date, such application will be subject to sufficient evidence of insurability. I have read and understand the "Important Information" located on the back of this form.

Employee Signature:_____ Date:_____
(Sign here if you are declining coverage)

D. Dependent Information
This section must be completed when enrolling your dependents (use additional paper if necessary)

Are you (☐enrolling ☐adding or ☐removing) your eligible (☐spouse and/or ☐dependents)?*
Please complete the following for each affected individual.

First Name	Initial	Last Name	Relationship	Date of Birth	Sex	Height/Weight	Social Security No.**

If any of the dependents you listed above (other than your spouse) are 19 or older and full-time students, please complete a Student Verification Form (available from either your agent or www.ushealthandlife.com) and submit it with this application and a current transcript or enrollment form.

**If you enroll Dependents with a different last name, you must provide proof of dependency (copy of adoption form, birth certificate, tax return or marriage license). ** Required by Federal and State law. We cannot process your enrollment form without it.*

E. Medical History Overview

This section must be completed if enrolling for coverage

Have you or any of your dependents to be covered under this plan been examined by a doctor, psychiatrist, psychologist or other practitioner within the past 24 months and;

1. Diagnosed with cancer, stroke, diabetes, heart or vascular disease, mental or emotional disorder, muscular, or systemic disease (including, but not limited to arthritis, lupus), alcohol or drug use, liver, kidney, lung or intestinal disorder, infertility, transplant (recommended, pending or completed) or growth disorder? ☐ Yes ☐ No
2. Incurred medical claims in excess of $5,000? ☐ Yes ☐ No
3. Have been prescribed medications and/or are taking medication for the treatment of an on-going or chronic condition? ☐ Yes ☐ No
4. Been advised of a prgenancy? ☐ Yes ☐ No
5. Been advised that surgery or treatment is needed or pending? ☐ Yes ☐ No

If you answered "Yes" to any of these questions, please be sure to complete Section F, otherwise please turn form over and complete the back page.

F. Medical History

Complete only if you answered yes in section E and enrolling for coverage

Have you or your dependents been diagnosed, treated, received counseling or advice during the past five years for any of the following:

PLEASE CHECK "YES" OR "NO" AND EXPLAIN ALL "YES" ANSWERS. USE AN ADDITIONAL PAGE IF NEEDED.

Cancer/Tumor
☐ Yes ☐ No

☐ Lung ☐ Breast ☐ Liver ☐ Colon ☐ Leukemia/Lymphoma ☐ Melanoma
☐ Prostate ☐ Other: _____
Patient Name: _____ Date Diagnosed: _____ Treatment: _____
Date Last Treated: _____ Current Status: _____ Stage/Level: _____

Heart/Circulatory
☐ Yes ☐ No

☐ Varicose Veins ☐ Skin Ulcer ☐ Phlebitis ☐ Stroke ☐ Aneurysm
☐ Blood Disorder ☐ Hemophilia ☐ Heart Disease ☐ Congestive Heart Failure
☐ Bypass/Angioplasty (# of vessels involved): _____
☐ High Blood Pressure (Last 3 readings & dates of readings): _____
☐ High Cholesterol (Most recent reading & date of reading): _____
Patient Name: _____ Date Diagnosed: _____ Treatment: _____
Date Last Treated: _____ Current Status: _____

Reproductive
☐ Yes ☐ No

☐ Current Pregnancy (Due date: _____) ☐ Multiples Expected _____
☐ Pregnancy Complications (current or past) ☐ Infertility ☐ Endometriosis
☐ Breast Disorders ☐ Other: _____
Patient Name: _____ Date Diagnosed: _____ Treatment: _____
Date Last Treated: _____ Current Status: _____

Intestinal/Endocrine
☐ Yes ☐ No

☐ Gallbladder ☐ Liver Disorder ☐ Hepatitis B/C ☐ Colon Disorder (provide diagnosis)
☐ Thyroid Disorder ☐ Crohn's/Ulcerative Colitis ☐ Diabetes ☐ Ulcer
☐ Chronic Pancreatitis ☐ Hiatal Hernia/GI Reflux ☐ Colitis
Last Hemoglobin A1C: _____ Fasting Blood Sugar: _____ Other:
Patient Name: _____ Date Diagnosed: _____ Treatment: _____
Date Last Treated: _____ Current Status: _____

Brain/Nervous
☐ Yes ☐ No

☐ Multiple Sclerosis ☐ Paralysis ☐ Cerebral Palsy ☐ Migraines
☐ Parkinson's Disease ☐ Alzheimer's Disease ☐ Epilepsy (Type & Date of last seizure) _____
Other: _____
Patient Name: _____ Date Diagnosed: _____ Treatment: _____
Date Last Treated: _____ Current Status: _____

Immune
☐ Yes ☐ No

Have you or any of your dependents been diagnosed or received treament during the past five years for any of the following?
☐ Lupus ☐ HIV+ ☐ AIDS ☐ Other:
Patient Name: _____ Date Diagnosed: _____ Treatment: _____
Date Last Treated: _____ Current Status: _____

Lungs/Respiratory
☐ Yes ☐ No
☐ Asthma ☐ Allergies ☐ Cystic Fibrosis ☐ Emphysema / Chronic Bronchitis
☐ Pneumonia ☐ Tuberculosis ☐ Sleep Apnea ☐ Other: _____
Patient Name: _____ Date Diagnosed: _____ Treatment: _____
Date Last Treated: _____ Current Status: _____

Eyes/Ears/ Nose/Throat
☐ Yes ☐ No
☐ Retinopathy ☐ Cleft lip/palate ☐ Chronic Sinusitis ☐ Deviated Septum
☐ Acoustic Neuroma ☐ Glaucoma ☐ Cataracts ☐ Chronic Ear Infections
Other: _____
Patient Name: _____ Date Diagnosed: _____ Treatment: _____
Date Last Treated: _____ Current Status: _____

Urinary/Kidney
☐ Yes ☐ No
☐ Renal Failure ☐ Polycystic Kidney Disease ☐ Neurogenic Bladder ☐ Kidney Stones
☐ Prostate Disorder ☐ Other: _____
Patient Name: _____ Date Diagnosed: _____ Treatment: _____
Date Last Treated: _____ Current Status: _____

Bones/Muscles
☐ Yes ☐ No
☐ Bulging/Herniated Disc ☐ Pituitary Dwarfism ☐ Spina Bifida ☐ Arthritis (Rheumatoid or Osteo)
☐ Joint Injury ☐ Pulled/Strained Muscle ☐ Other Back/Neck Disorders
Other: _____
Patient Name: _____ Date Diagnosed: _____ Treatment: _____
Date Last Treated: _____ Current Status: _____

Mental Health/ Substance Abuse
☐ Yes ☐ No
☐ Alcoholism ☐ Eating Disorder ☐ Anxiety/Depression ☐ Bipolar/Manic Depression
☐ Drug Abuse ☐ Suicide Attempt ☐ Attention Deficit Disorder ☐ Other: _____
Patient Name: _____ Date Diagnosed: _____ Treatment: _____
Date Last Treated: _____ Current Status: _____

Transplant
☐ Yes ☐ No
☐ Organ: _____ ☐ Bone Marrow
☐ Discussed possible future transplant ☐ Surgery Completed (Date: _____)
Patient Name: _____ Current Status: _____

Medication
☐ Yes ☐ No

Member/Dependent Name	Medication	Daily Dosage	Frequency

Additional medication? ☐ Yes ☐ No If "Yes," please attach sheet.

Other
☐ Yes ☐ No
☐ Treatment, surgery or diagnostic testing discussed or advised, but not yet done ☐ Abnormal test or physical results
☐ Condition or Congenital Disorder not mentioned above ☐ Unexplained Weight Change
Patient Name: _____ Date: _____
Details: _____

Tobacco Use
☐ Yes ☐ No
☐ Has anyone on this application smoked or used tobacco products during the past 12 months?
If yes, indicate the number of packs per day along with the number of years.
Packs/Day: _____ Years: _____
Name(s): _____

Alchohol Use
Yes No
How frequently do you drink alcohol _____ Type of alcohol: _____

Please give the name and telephone number of your current doctor/doctors.

_____

_____

_____

Additional Explanations: Please attach a sheet if additional explanation is needed and indicate which section you are referencing.

G. Other Insurance Information

Only complete this section after section E and if enrolling in coverage

Other than existing employer provided coverages, are you or any of your eligible dependents covered under any of the following other medical insurance coverages:

Source	Who is Covered?	Name of Covered	Effective Date	Name of Carrier	Type of Coverage
Spousal:	☐You ☐Spouse ☐Dependent	_____	_____	_____	☐Medical ☐Rx ☐Dental
Individual Plan:	☐You ☐Spouse ☐Dependent	_____	_____	_____	☐Medical ☐Rx ☐Dental
Medicaid:	☐You ☐Spouse ☐Dependent	_____	_____	_____	☐Medical ☐Rx ☐Dental
Medicare:	☐You ☐Spouse ☐Dependent	_____	_____	_____	☐Medical ☐Rx ☐Dental

Reason for Medicare eligibility ☐Age 65 or Over ☐Disabled ☐Kidney Disease Date Eligible:_____

Have you received a Certificate of Creditable Coverage in the last 15 months? ☐Yes ☐No If yes, please attach the certificate to this application.

H. Employee Agreement/Authorization to Release HIPAA Medical Information

This section must be completed even if declining coverage

Agreement: I apply to US Health and Life Insurance Company for coverage. I declare that all of the statements contained in this enrollment form, to the best of my knowledge, are true and correct, and that no material insurance information has been withheld or omitted concerning the past or present state of health of myself or of my named dependents. I understand and agree that the Insurer is not bound by any statement made by or to any agent unless documented in this enrollment form. I understand that any misstatements about medical history could result in denial of an otherwise valid claim and voiding or reformation of insurance.

I acknowledge reading the entire completed enrollment form and the insurance agent has explained the coverages, limitations and exclusions, other details of coverage of the insurance applied for, and the underwriting rules and regulations of the Insurer. No agent has the authority to bind or alter coverage.

I have read the notice explaining the use of the Medical Information Bureau. I authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau, or Consumer Reporting Agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and or HIV/AIDS test results or diagnosis and/or treatment of me or my named dependents and other non-medical information of me or my named dependents, to give to US Health and Life Insurance Company or its legal representative, any and all such information.

I understand that any information obtained will not be released by the Insurer to any persons or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my application for insurance, for any claims, or as may be otherwise lawfully required or as I may further authorize.

I understand that I may request a copy of this authorization at anytime.

Employee Name (printed): _____

Employee Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

(Required if spouse is enrolling for coverage)

Your Privacy Is Protected

US Health and Life Insurance Company (USHL), like other health insurance companies, sometimes evaluates present and past medical history of applicants to determine their eligibility for certain policies.

With USHL, this evaluation is limited to specific insurance policies and the applications for those clearly show this requirement.

I authorize the use and disclosure of my protected health information as described below:

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (1) my past, present, or future physical or mental health or condition; (2) the provision of health care to me; or (3) the past, present, or future payment for the provision of health care to me.

US Health and Life Insurance Company is authorized to use or disclose my protected health information. My protected health information will be used or disclosed only for the purposes of administering the insurance certificate subject of this application.

I understand that I may revoke this authorization at any time by sending a written notification to US Health and Life Insurance Company at 8220 Irving Road, Sterling Heights, MI 48312, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (1) for information that US Health and Life Insurance Company already has used or disclosed, relying on this authorization or (2) if the authorization was obtained as a condition of coverage.

Any information you give USHL or its insurer regarding your insurability will be treated strictly confidential. USHL, or its Insurers, may make a brief report on information received with your application to the Medical Information Bureau. (A nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. P.O. Box 105, Essex Station, Boston, MA 02112. Phone: 617-426-3660). The Bureau, upon request from a member company to whom you may apply for insurance or to whom a claim for benefits may be submitted, will supply the company with such information. If you ask, the Bureau will arrange disclosure of the information in your file and you may seek to correct any inaccuracy in accordance with the Fair Credit Reporting Act procedures.

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For Office Use Only

RECV'D _____ EFF DATE _____ MED_____ CLASS _____

ENT'D_____ DIVISION #_____ DEN _____ LIFE _____