USAble Life

EMPLOYEE GROUP HEALTH COVERAGE APPLICATION

(For employer groups with 51 or more employees)

Please check the appropriate box and fill in blanks below in ink.

Group No.: **I.D. No.:**

GROUP ADMINISTRATOR USE ONLY
Class :

Is the Employee waiving coverage in the plan? ○ Yes ○ No If yes, complete Sections 1, 3 & 7 only.

FOR OFFICE USE ONLY

○ USAble Life group health coverage ○ USAble Life HSA
○ USAble Life HRA ○ Life Only (complete Sections 1,2, 3, 5 & 7)

○ New Enrollee
○ Loss of Other Coverage
○ Add a Family Member:
○ Newborn — Date of Birth: ______________________
○ Marriage — Marriage Date: (Submit copy of marriage certificate.)

Date of Full-Time Employment			○ COBRA Effective Date			○ COBRA Termination Date			Reason for COBRA:
Mo.	Day	Year	Mo.	Day	Year	Mo.	Day	Year	

SECTION 1. EMPLOYEE INFORMATION

First Name:	Middle Name:	Last Name:	Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed

Home Address:	City:	State:	Zip Code:

Home Phone No.:	Work Phone No.:	Employer:	Job Title:

Coverage Desired: ○ Employee Only ○ Employee & Spouse ○ Employee & Child(ren) ○ Employee, Spouse & Child(ren)

Employment Status: ○ Hourly ○ Salaried ○ Other Hours Worked Weekly: _______

SECTION 2. (Complete this section on all members to be covered.)

Social Security Number	First Name	M. I.	Last Name	Birth Date Mo/Day/Yr	Sex M or F	Height/ Weight	$ Amt/Yrs Deductible Credit Submitted*
Employee _____ - ______ - ______						Ht.________ Wt.________	
Spouse _____ - ______ - ______						Ht.________ Wt.________	
Child - ○Nat. ○Step ○Adop. _____ - ______ - ______						Ht.________ Wt.________	
Child - ○Nat. ○Step ○Adop. _____ - ______ - ______						Ht.________ Wt.________	
Child - ○Nat. ○Step ○Adop. _____ - ______ - ______						Ht.________ Wt.________	
Child - ○Nat. ○Step ○Adop. _____ - ______ - ______						Ht.________ Wt.________	

College Student's Name	Name of Accredited School/College at which dependent is a full-time student	City	State

Do all dependents listed above reside at the same address as employee? ○ Yes ○ No
If NO, list dependent(s) name and address:

SECTION 3. WAIVER OF ENROLLMENT/SPECIAL ENROLLMENT RIGHTS

To be completed if coverage is declined or refused by an eligible employee and/or their eligible family members.

1. Medical Coverage Declined for:		
	○ Covered by spouse's group coverage – Carrier Name and ID :	
○Myself	○ Enrolled in other Insurance Carrier Plans – Carrier Name and ID:	
○Spouse	○ Medicare	○Covered by TRICARE or CHAMPVA
○Dependents	○ Other (Explain):	

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C/T	PKG	WWP
Eff Date	IMP	
Life	AD&D	
Timely____ Late______	UND	Date
OTHER		

*Deductible Credit is available for new group enrollments but only if the individual requests it on this initial application

USAble LGAPP
44-02 7/07

SECTION 3. WAIVER OF ENROLLMENT/SPECIAL ENROLLMENT RIGHTS (continued)

I hereby certify that: (1) I have been given the opportunity to apply for the coverage made available through my employer under the applicable policy. The coverages and the policy have been thoroughly explained to me, and I decline to apply for coverage for myself and/or my dependent(s) as listed above; and (2) I understand that if I refuse to apply now and I apply for coverage at a later date, I may be enrolled as a Late Enrollee or my request may be deferred until open enrollment.

Special Enrollment Period. If you are declining enrollment for yourself or your dependent(s) (including your spouse) because of other insurance coverage, in order to enroll yourself and/or your dependents in your employer's plan in the future without being considered a Late Enrollee you must: (1) Indicate on this application form that the reason you or your dependent(s) are declining coverage now is because you or your dependent(s) have coverage under another group health plan; and (2) Submit a Group Enrollment Form to enroll yourself or your dependent(s) within 30 days after coverage ends under the other group health plan. 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, your spouse and/or your new dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

SECTION 4. OTHER MEDICAL INSURANCE

(This section must be completed to process your enrollment application.)

○ **Yes** ○ **No** On the day coverage begins will any family members be covered by other health or dental insurance or Medicare, including continuation of coverage? If yes, answer all questions below. (Use additional paper if necessary)

○ **Yes** ○ **No** Is the continuing coverage Medicare? If so, complete the following:
Reason for Medicare coverage: ○ Over 65 ○ Disabled ○ Kidney Disease

Medicare Beneficiary Name:

Medicare Health Identification Contract (HIC) Number:

Relationship of Beneficiary to Policyholder:

Type of Medicare Coverage (check all that apply) ○ Medicare Part A – Effective Date: ○ Medicare Part B – Effective Date:

○ **Yes** ○ **No** Is the continuing coverage other than Medicare? If so, complete the following: (if covered by more than one insurance plan, use additional pape

Name of Insurer:	Address:	Phone:

Policyholder Name::	Date of Birth:	Member ID #:

List the following information for all family members covered by this policy (indicate those not residing in your household with a check ümark)

First Name	Last Name	Relationship	ü	Effective Date of Coverage

For members listed above, are you responsible for providing primary health insurance coverage? ○ Yes ○ No – Please name responsible party:

SECTION 5. LIFE INSURANCE (Issued for any employer with 51-100 employees)

I hereby designate the beneficiary or beneficiaries listed below under this certificate and revoke the appointment of any existing beneficiary.

First Name	M.I.	Last Name	Date of Birth	Relationship

SECTION 6. PROOF OF PRIOR COVERAGE

○ **Yes** ○ **No** Do you or any dependent listed in this application currently have or have you (they) had any health coverage within the past 63 days? If YES, please provide the coverage history for the past 18 months in the spaces below.

If the insurance coverage for which you are making application contains a pre-existing condition limitation period, you may be able to offset part of all of such period by attaching a Certificate of Creditable Coverage to this application. Federal and state law require your prior health plan(s) or health insurance company(ies) to provide you such Certificate(s) of Creditable Coverage upon request. If for some reason you are unable to attach such a Certificate of Creditable Coverage, please include whatever documents you have (i.e. explanation of benefits forms, correspondence from your former health plan or health insurer, former identification card, or benefit certificate) which will assist us to corroborate your prior creditable coverage.

Name of Persons Covered	Name, Address, Phone No. & Policy No. of Prior Health Insurance Co.	Effective Date	Termination Date	Reason for Termination

SECTION 7. UNDERSTANDINGS, REPRESENTATIONS AND AGREEMENTS (PLEASE READ BEFORE SIGNING IN INK.)

I understand that the benefits for which I (we) will be eligible are those described in the USAble Life group policies with my employer as may from time to time be amended. I understand that coverage will not become effective before the approved effective date. I understand that in addition to other exclusions and limitations provided in the USAble Life group policies, NO BENEFITS WILL BE AVAILABLE DURING THE APPLICABLE PRE-EXISTING CONDITION EXCLUSION PERIOD FOR TREATMENT OF ANY CONDITION FOR WHICH A COVERED PERSON RECEIVED MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WITHIN THE SIX (6) MONTH PERIOD ENDING ON THE EFFECTIVE DATE OR THE FIRST DAY OF THE WAITING PERIOD, WHICHEVER IS EARLIER.

In signing below, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded; (b) authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance or reinsurance company or any third party engaged by USAble Life to secure medical or non-medical information having information with respect to any physical or mental condition, treatment or any non-medical information on me, or any member of my family (if applicable), to give USAble Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (c) authorize all said sources to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (d) understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage and that this information shall also be used by USAble Life, its reinsurers, or its legal representative may disclose this information to others as required or permitted by law and as set out in its Notice of Privacy Practices; (e) understand that I may terminate this authorization by sending a written revocation to USAble Life, 320 W. Capitol, Suite 500, Little Rock AR 72203; (f) unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; (g) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Print Name of Applicant	Signature of Applicant	Date
Print Employer/Group Administrator*	Signature Employer/Group Administrator*	Date

**Required for new hires and additions only.*