

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.

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, including Medicaid; and (2) Submit a Group Enrollment Form to enroll yourself or your dependent(s) within 31 days after coverage ends under the other group health plan. In addition, if you have a new dependent as a result of a court or administrative order, marriage, birth, adoption, becoming a party to a suit for adoption, you may be able to enroll yourself, your spouse and/or your new dependent(s), provided that you request enrollment within 31 days after the a court or administrative order, marriage, birth, adoption, or becoming a party to a suit for adoption

SECTION 4. OTHER MEDICAL INSURANCE

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

Will you, your spouse or dependents be continuing any other health insurance coverage, including Medicare? Yes No

If you answered Yes, complete Part 1 and/or Part 2 as applicable – (Use additional paper if necessary)

Part 1: If continuing coverage is Medicare, 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:

Part 2: If continuing coverage is other than Medicare, complete the following -- (if covered by more than one insurance plan, use additional paper)

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)

First Name	Last Name	Relationship	<input type="checkbox"/>	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 (Offered by USABLE Life for any employer with 2-100 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. CREDITABLE COVERAGE INFORMATION

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 compan(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.

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

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 USABLE LIFE BENEFITS WILL BE AVAILABLE FOR UP TO 12 MONTHS FROM MY EFFECTIVE DATE OR THE FIRST DAY OF MY WAITING PERIOD. IF I AM A LATE ENROLLEE THE PERIOD OF PREEXISTING CONDITION EXCLUSION WILL BE 18 MONTHS FROM THE DATE I SUBMIT THIS APPLICATION

In signing this application, I represent that the statements and answers given in this application are true, complete and correctly recorded. I understand that USABLE Life may, within two years of the date of this application, void or terminate this coverage or deny claims for coverage if incorrect information has been given on this application. If fraudulent misstatements were made, USABLE Life may take legal action at any time

Print Name of Applicant

Signature of Applicant

Date

Print Employer/Group Administrator*

Signature Employer/Group Administrator*

Date

**Required for new hires and additions only.*