



**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.)**

**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 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  mark)

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 to 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. 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. MEDICAL 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 to the questionnaire. **YOUR COVERAGE CANNOT BE DECLINED BASED ON HEALTH STATUS RELATED FACTORS.** However, **INTENTIONAL MISREPRESENTATION OF MATERIAL FACT MAY RESULT IN TERMINATION OR RESCISSION OF COVERAGE WITHIN THE FIRST TWO POLICY YEARS.**

1.  **Yes**  **No** Has any person to be insured ever been declined, surcharged, rescinded or restricted for the issuance of life, health or accident insurance? If "Yes," Member: \_\_\_\_\_ Reason: \_\_\_\_\_
2.  **Yes**  **No** Has any person to be insured ever been insured with USAble Life? If "Yes," Member: \_\_\_\_\_
3.  **Yes**  **No** Has any person to be insured used tobacco in the last 12 months? If "Yes", Member: \_\_\_\_\_ What type? \_\_\_\_\_

In the past 10 years, has any person to be insured ever been diagnosed or been advised by a physician to have treatment or care for any of the following conditions? **Check the appropriate box(es) below and explain in the Additional Medical Information section.**

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32.  **Yes**  **No** In the past 10 years, has any person to be insured ever been hospitalized, received hospital services or had surgery? (If "Yes" give full details in the Additional Medical Information Section below.)
33.  **Yes**  **No** In the past 10 years, has any person to be insured ever seen, or been advised to see a health care provider, surgeon, chiropractor, counselor, psychiatrist, social worker, pain specialist, physical therapist, speech therapist, rehabilitation therapist, occupational therapist, oncologist, or endocrinologist? (Circle each provider and give details in the Additional Medical Information Section below.)

**ADDITIONAL MEDICAL INFORMATION** List below full details to questions answered "Yes." (Additional space available on the next page.)

Question Number	Person Treated	Condition & Type of Treatment	Date Occurred	Last Date of Treatment	Current Status	Complete Name and Address of Physician

34.  **Yes**  **No** In the past 2 years, has any person to be insured discontinued or failed to take medication prescribed by a physician? If "yes" list full details below. (Additional space available on the next page.)
35.  **Yes**  **No** Has any person to be insured been prescribed or taken any prescription medication for more than a total of 30 days in the past 2 years? If "yes" list full details below. (Additional space available on the next page.)

**PRESCRIPTION INFORMATION**

Person Treated	Name of Drug	Dosage	Condition or Illness	Start Date	Stop Date	Complete Name & Address of Physician

