ASSURANT Health

GROUP INSURANCE
EMPLOYEE ENROLLMENT FORM

PRINT ALL INFORMATION – USE INK, NOT PENCIL
TO BE COMPLETED BY THE EMPLOYEE

Group # __________ Certificate # __________ Name of Employer ______________________________________

Employer Phone # ______________________________ Employer Fax # ______________________________

Check One: ❑ 1st Enrollment ❑ Adding Dependent(s) (Date of Marriage/Birth)________ ❑ Adding Medical ❑ Other

A. EMPLOYMENT AND PERSONAL INFORMATION

Name of Employee Last First MI | ❑ Male ❑ Female | ❑ Single ❑ Married

Home Address Street | City | State | Zip | Home Phone ( ) -

Full-time Employment Date: / / | **Job Duties:**

Hours Worked Per Week: | **Monthly Earnings** $ | **Earnings Basis:** ☐ Salaried ☐ Hourly ☐ Commission

Employee Status: ❑ Active ❑ Continuation ❑ COBRA ❑ Other Leave | **Effective Date of COBRA/Continuation or Other Leave:** (Month/Day/Year) / /

B. COVERAGE REQUESTED (Medical history [Section F] required for Medical, Life & DI coverage only)

LIFE/AD&D AMOUNT: $ __________,000 **DISABILITY AMOUNT:** $ __________/Week

Name of Beneficiary ____________________ SS# _____–_____–_____

Relationship to Employee ______________________________

If no beneficiary is designated, death benefits will be payable to your estate.

MEDICAL: ❑ None* ❑ Single ❑ Employee & Spouse ❑ Employee & Children ❑ Full Family

Groups with multiple medical plans, indicate which plan you are requesting ❑ Plan 1 ❑ Plan 2

*If waiving Medical coverage on yourself or your dependents, please fully complete Section D.

DENTAL: ❑ None* ❑ Single ❑ Employee & Spouse ❑ Employee & Children ❑ Full Family

*If waiving Dental coverage on yourself or your dependents, please fully complete Section D.

C. PERSONS TO BE COVERED

Name (Include yourself and all family members to be insured) Last Name First Name	Relationship	Date of Birth (Mo/Day/Yr)	Social Security Number	Current Height (Ft/In)	Current Weight (Lbs)	Has tobacco in any form been used in the past 12 months?	Full-time Student (age 19+)
	Employee	/ /	- -			❑ Yes ❑ No	
	Spouse	/ /	- -			❑ Yes ❑ No	
	Child ❑ M ❑ F	/ /	- -			❑ Yes ❑ No	❑ Yes ❑ No
	Child ❑ M ❑ F	/ /	- -			❑ Yes ❑ No	❑ Yes ❑ No
	Child ❑ M ❑ F	/ /	- -			❑ Yes ❑ No	❑ Yes ❑ No
	Child ❑ M ❑ F	/ /	- -			❑ Yes ❑ No	❑ Yes ❑ No

(continued on next page)

D. WAIVER OF COVERAGE: This section must be completed if you OR your dependents DO NOT want coverage.

I understand that I am eligible to apply for coverage through my employer. I **DO NOT** want coverage for (check ALL that apply):

❑ Myself ❑ Spouse ❑ Children

Reason for waiving:
- ❑ Coverage under spouse's group plan
- ❑ Individual medical plan
- ❑ Medicare/Medicaid
- ❑ Other ___________________________

Carrier Name: ___________________________________

Phone Number: ___________________________________

Policy Number: ___________________________________

OR (Provide a copy of the ID card)

E. PRIOR INSURANCE COVERAGE INFORMATION – FAILURE TO SUPPLY COMPLETE INFORMATION MAY RESULT IN A PRE-EXISTING CONDITION LIMITATION.

Have you, your spouse or dependent children been covered by any type of medical plan within the last 18 months?
❑ Yes ❑ No If yes, list all plans in effect during the past 18 months.

Covered Persons	Insurance Company Name/Telephone #/Policy #	**Effective Date**	**Termination Date**	**Reason for Termination**
❑ Employee ❑ Spouse ❑ Child				
❑ Employee ❑ Spouse ❑ Child				

Will your current medical plan terminate if coverage is approved by Time Insurance Company? ❑ Yes ❑ No

If Yes, when ____

F. HEALTH HISTORY (Give complete details in Section G)

1. Have you or any of your dependents included on this enrollment form:
   a. Within the past 5 years, been confined in a hospital, emergency room or other medical facility OR had medical expenses in excess of $3,000 in any one year? ☐ Yes ☐ No
   b. Taken any prescribed medication in the past 18 months and/or are you currently taking any prescribed medication? ☐ Yes ☐ No
   c. In the past 18 months, been seen or treated by any health care provider, including routine follow-up or ongoing medical care, any consultation, treatment, therapy, medication, advice or undergone any testing? ☐ Yes ☐ No
   d. Been advised of the possibility or necessity of any future treatment, testing or surgery? ☐ Yes ☐ No

   If you have answered Yes to any of the above questions, please provide complete details in Section G.

2. Have you or any of your dependents included on this enrollment form ever been diagnosed with or treated for:
   a. Cancer/Tumor; Chest Pain; Heart Attack/Bypass/Angioplasty; Hodgkin's/ Lymphoma/Leukemia; Liver Disorder/Hepatitis; Stroke; or tested positive, been counseled or been treated for Human Immunodeficiency Virus (HIV) or acquired immune deficiency syndrome (AIDS)? ☐ Yes ☐ No
   Other ____?
   b. Alcohol or Drug Usage; Asthma/Bronchitis; Back Pain; Arthritis; Crohn's Disease; Diabetes Mellitus; Hypertension/High Blood Pressure; Nervous System Disorders/ Seizures; Mental or Nervous Disorders; Ulcerative Colitis; or a partial or total Disability? ☐ Yes ☐ No
   Other ________________________________?

   If you have answered Yes to any of the above questions, please circle the appropriate condition(s) and provide complete details in Section G.

3. Are you or any of your dependents currently pregnant, an expectant parent, in the process of adopting a child or undergoing or have undergone infertility treatment? ☐ Yes ☐ No
   Due Date _______________

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G. PLEASE GIVE COMPLETE DETAILS TO ALL MEDICAL QUESTIONS THAT HAVE BEEN ANSWERED YES.

Complete all columns. If more space is needed, attach an additional sheet of paper which must be signed and dated.

Ques #	Person Treated	Nature of Condition and/or Diagnosis	Duration Dates From	To	Explain Treatment: Include dates of Disability, Hospitalization, Medication (include dosage), Tests and Surgery	Results/Degree of Recovery

If more space is needed, attach an additional sheet of paper which must be signed and dated.

H. IMPORTANT NOTICE

I hereby represent that I am an employee of the participating employer and that the statements and answers to the questions on this enrollment form are true and complete to the best of my knowledge and belief and will be used by Time Insurance Company to determine eligibility for insurance for myself and persons listed on this enrollment form as my spouse or dependent children.

When applicable, I authorize my employer to deduct contributions from my earnings to be applied to the cost of insurance. I understand that (1) the answers given will be the basis of any coverage provided; (2) coverage, if approved, may be subject to limitations regarding preexisting conditions as defined by the certificate of insurance; (3) any material misrepresentations or failure to provide complete information to questions on this enrollment form may be used as a basis for reformation or rescission of my coverage; (4) if coverage is not approved, I, my spouse or dependent children are not entitled to benefits; (5) if I, my spouse or dependent children waive coverage and decide to apply for coverage at a later date, evidence of insurability may be required and benefits may be deferred for a specified period of time; and (6) coverage will not be effective until I receive notice that this enrollment form has been approved by the Company.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, pharmacy or pharmacy-related facility; insurance company, reinsurer, or consumer reporting agency to give to Time Insurance Company any information regarding diagnosis, treatment and prognosis with respect to any physical, mental or dental condition or any other information pertaining to employment or other medical insurance for me or any member of my family shown on this enrollment form. I further authorize Time Insurance Company to disclose such information to any third parties utilized to provide services or benefits relating to my insurance contract; or any request for such information which Time Insurance Company is legally required to provide. I agree that this authorization shall remain valid for two years from the date signed and that a photocopy of this authorization will be as valid as the original.

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an enrollment form or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Employee's Signature ______________________________ Date ____________________