

**Instructions for completing this enrollment form**

- 1) Each eligible employee enrolling for any coverage offered must complete the entire enrollment form except **Section B**, which must be completed only if enrolling in an existing plan or making changes to an existing plan.
- 2) Any eligible employee waiving all coverages offered, only needs to complete and sign the Waiver of Coverage in **Section G**.
- 3) This enrollment form must be completed in ink.
- 4) If your employer offers multiple medical plans, please review the options with your employer.

Name of Employer: \_\_\_\_\_

Your Work Address: \_\_\_\_\_

**SECTION A – EMPLOYEE INFORMATION**

 Employee's Name: \_\_\_\_\_  
*Last* *First* *MI*

 Employee's Address: \_\_\_\_\_  
*Street* *City* *State* *Zip*

Home Phone: (\_\_\_\_) \_\_\_\_\_ Best Time to Call: a.m. p.m.      Work Phone: (\_\_\_\_) \_\_\_\_\_ Best Time to Call: a.m. p.m.

E-mail Address: \_\_\_\_\_

 Are you a U.S. Citizen?     Yes     No

 Are you a legal resident?     Yes     No

**Marital Status:**
 Single     Married (Date of Legal Marriage: \_\_\_\_\_)     Divorced (Date of Legal Divorce: \_\_\_\_\_)

Full-time Employment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_      Occupation/Job Duties: \_\_\_\_\_

Hours worked per week for this employer: \_\_\_\_\_      Monthly Earnings: \$\_\_\_\_\_

**Earnings Basis:**     Salaried     Hourly     Commission

**Employee Status:**     W2     1099     Owner/Partner     Other (specify): \_\_\_\_\_

**Current Status:**     Currently Working     COBRA     Continuation     Disability     Retired     Other Leave

Effective Date of COBRA/Continuation or Other Leave (MM/DD/YYYY): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**SECTION B (Only to be completed by additions to existing groups or for changes to existing coverage.)**

Group #: \_\_\_\_\_      Requested effective date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (Subject to Underwriting approval)

 This enrollment is for (check one):     New Enrollee     Coverage Change (specify)

 Adding Spouse     Adding Dependent Coverage

 Other Change (specify type): \_\_\_\_\_      # of Children: \_\_\_\_\_

Groups with multiple medical plans, indicate which plan you are requesting.\*    Medical Plan #: \_\_\_\_\_

Groups with multiple dental plans, indicate which plan you are requesting.\*    Dental Plan #: \_\_\_\_\_

*\*Please contact your employer for the plan options/descriptions which are identified on your employer's billing statement and/or quote.*

**Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.**

**SECTION C – COVERAGE REQUESTED** (Medical history and details sections required for Medical, Life, Disability coverages only.)

**\*\* If waiving coverage on yourself, and/or your dependents, please fully complete the Waiver of Coverage in SECTION G of this enrollment form.**

**MEDICAL:**     None\*\*     Employee Only     Employee & Spouse     Employee & Children     Employee, Spouse & Children

**DENTAL:**     None\*\*     Employee Only     Employee & Spouse     Employee & Children     Employee, Spouse & Children

**LIFE / AD&D AMOUNT:** \$ \_\_\_\_\_ (If no beneficiary is designated, benefits will be paid according to the terms of the Certificate of Insurance or to your estate.)

Name of Beneficiary: \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

**DEPENDENT LIFE AMOUNT:** \$ \_\_\_\_\_

**SHORT TERM DISABILITY: Amount or monthly earnings:** \$ \_\_\_\_\_

**SECTION D – PERSON(S) TO BE COVERED**

(Include yourself and all family members to be insured. If more space is needed, attach an additional sheet.)

Last Name	First Name	Relationship & Gender	Date of Birth (MM/DD/YYYY)	State of Birth	Social Security Number	Full-Time Student (age 19+)
		Employee <input type="checkbox"/> M <input type="checkbox"/> F				
		Spouse <input type="checkbox"/> M <input type="checkbox"/> F				
		Child <input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
		Child <input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
		Child <input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No

Please explain if any child listed above is (a) not your natural child, legally adopted child or stepchild, (b) not solely supported by you, or (c) not permanently residing in your household. \_\_\_\_\_

**SECTION E – MEDICAL HISTORY**

	Height	Weight	Used any form of tobacco/nicotine in the last 12 months?
<b>Employee</b>			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Spouse</b>			<input type="checkbox"/> Yes <input type="checkbox"/> No

1. List all medications prescribed in the past 18 months for you and any dependents included on this enrollment form. (Include pills, creams, injections, liquids, inhalers, pumps, etc.)

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

Individual (Full Name)	Name of Medication	Dosage & Frequency of Use	Date Prescribed	Date Last Used	Condition(s) Being Used For

For all "YES" answers to the following questions, provide full details in SECTION F on next page.

2. Have you or any of your dependents included on this enrollment form within the past 10 years been diagnosed with or treated for any of the following (If "Yes," circle all that apply): .....  Yes  No  
Cancer/Tumor; Chest Pain; Respiratory/Lung Disorders; Heart Attack/Bypass/Angioplasty; Heart Disorders; Vascular Disorders; Systemic Lupus Erythematosus; Hodgkin's/Lymphoma/Leukemia; Blood Disorders; Immune Disorders; Liver Disorder/Hepatitis; Multiple Sclerosis (MS); Stroke; or Tested Positive or Been Treated for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), Sexually Transmitted Diseases?
3. Have you or any of your dependents included on this enrollment form within the past 5 years been diagnosed with or treated for any of the following (If "Yes," circle all that apply): .....  Yes  No  
Asthma; Back Disorders; Muscle Disorders; Osteoarthritis, Rheumatoid or other Arthritis; Skeletal Disorders; Crohn's Disease; Ulcerative Colitis; Digestive Disorders; Urinary Disorders; Kidney Disorders; Seizures; Paralysis; Nervous System Disorders; Ear/Eye/Nose/Throat Disorders; Reproductive Disorders; Endocrine Disorders; any Other Physical Disorder or Deformity or a Partial or Total Disability?
4. Have you or any of your dependents included on this enrollment form:
- a. Within the past 5 years, been confined in a hospital, residential treatment center, mental health, or medical facility, or had outpatient surgery or had medical expenses in excess of \$3,000 in any one year or been absent from work, school, confined to home or incapacitated for more than 2 consecutive weeks due to illness or injury? .....  Yes  No
  - b. In the past 18 months, been seen by any health care provider for emergency services, routine follow-up or ongoing medical care; received consultation, treatment, therapy, advice or undergone any testing? .....  Yes  No
  - c. Been advised of the necessity or possibility of any future hospitalization, treatment, testing or surgery? .....  Yes  No
  - d. Been receiving Workers' Compensation? .....  Yes  No
- If "Yes", provide name and telephone number of claims processor. \_\_\_\_\_
5. Have you or any of your dependents included on this enrollment form received any treatment, including but not limited to counseling for alcoholism, or chemical, alcohol or drug abuse or addiction, used illegal drugs or prescription medication other than as prescribed, been advised by a physician to discontinue or decrease alcohol consumption or drug use? .....  Yes  No
6. Have you or any of your dependents included on this enrollment form been treated for the following conditions, and if "Yes," provide the following information:
- a. Hypertension/High Blood Pressure .....  Yes  No  
If "Yes," list last 3 blood pressure readings: Current \_\_\_\_\_ 6 mo \_\_\_\_\_ 1 yr \_\_\_\_\_
  - b. Diabetes Mellitus (type):  Type 1 Juvenile Diabetes  Type 2 Adult Onset Diabetes.....  Yes  No  
If "Yes," check treatment:  Diet Controlled  Oral Medications  Insulin  Insulin Pump  
Date of onset: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Include your last Hemoglobin A1c Reading and Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
  - c. Diabetic Related Disorders (If "Yes", circle all that apply).....  Yes  No  
Heart Disease, Stroke, Kidney Impairments (Nephropathy), Visual Impairments (Retinopathy), Peripheral Vascular Disease, Nerve Impairments such as Numbness or Burning of Legs or Feet (Neuropathy)
  - d. Mental, Nervous or Behavioral Disorders .....  Yes  No  
Diagnosis: \_\_\_\_\_  
Treatment (If "Yes", circle all that apply):  
Inpatient Treatment, Outpatient Treatment, Counseling, Prescription Medication(s)
7. Are you or any dependents included on this enrollment form currently pregnant, an expectant parent, in the process of adoption, undergoing or have undergone infertility treatment? .....  Yes  No  
Are you anticipating complications for you or your unborn child and/or multiple births? .....  Yes  No  
Are you anticipating a cesarean section? .....  Yes  No  
Due Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date of Adoption: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**SECTION F – MEDICAL HISTORY DETAILS** (Details for all answers marked "YES" must be provided below.)

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

Question # and Letter	Individual (Full Name)	Diagnosis and/or Condition	Dates of Diagnosis and/or Condition	Explain Treatment Include any Hospitalization, Tests or Surgery	Results/Degree of Recovery and Current Status	Physician/ Specialty/ Hospital Telephone Number

**SECTION G – WAIVER OF COVERAGE**

(Complete and sign if waiving any or all coverages for self and/or dependents.)

All eligible employees and dependents must be listed as either enrolling or waiving coverage when first eligible. If you or any of your eligible dependents do not enroll in Time Insurance medical coverage when it is first made available and want to enroll in the future, your coverage may be subject to an extended pre-existing period exclusion. This pre-existing exclusion does not apply to maternity benefits. If you or any of your eligible dependents do not enroll in Time Insurance dental coverage when it is first made available and want to enroll in the future, your coverage may be subject to an extended waiting period for certain benefits. For further information on the late addition policy for group employers in your state, please contact your agent or a Time Insurance representative.

Person(s) Waiving	Coverage(s) to be Waived	Other Coverage(s)	Carrier Name(s)	ID No.(s)	Effective Date(s)
<input type="checkbox"/> Employee	<input type="checkbox"/> All <input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental			
<input type="checkbox"/> Spouse	<input type="checkbox"/> All <input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental			
<input type="checkbox"/> Child(ren)	<input type="checkbox"/> All <input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental			

Indicate the type of coverage in effect and for whom.

Type of Coverage	For Whom?		
<input type="checkbox"/> Spouse's Employer Plan	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)
<input type="checkbox"/> Medicare / Medicaid	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)
<input type="checkbox"/> Tricare	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)
<input type="checkbox"/> COBRA	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)
<input type="checkbox"/> Individual	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)
<input type="checkbox"/> Other, explain:	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)

Neither I nor my dependents have been induced or pressured to decline coverage by my employer, the agent, or Time Insurance Company. I and my dependents have waived such coverage of our own accord.

Signature: \_\_\_\_\_

Date of Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date of Full-time Employment: \_\_\_\_\_

**SECTION H – PRIOR INSURANCE COVERAGE INFORMATION**

*(Failure to supply complete information may result in a pre-existing condition limitation.)*

1. Have you and all dependents you are enrolling been covered by this employer’s major medical plan(s) for the past 12 months? .....  Yes  No
2. 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.**
3. Have you, your spouse or dependent children been covered by a dental plan within the last 12 months? .....  Yes  No  
**If “Yes,” was orthodontic treatment included? .....  Yes  No**

Covered Persons	Insurance Company Name and Policy #	Effective Date MM/DD/YYYY)	Termination Date MM/DD/YYYY)	Reason for Termination
<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child				
<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child				

Will any current medical plan remain active if coverage is approved?  Yes  No

If “Yes,” for whom? \_\_\_\_\_

**SECTION I – AUTHORIZATION AND SIGNATURE** *(Required if enrolling for any coverages for self and/or dependents.)*

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. I understand that the statements and answers contained herein 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 pre-existing conditions as defined by the certificate of insurance; (3) any fraud or intentional misrepresentation of material fact that is made on this enrollment form may be used as a basis for changing rates or terminating my coverage; (4) if coverage is not approved, I, my spouse and/or dependent children are not entitled to benefits; (5) if I, my spouse and/or dependent children waive coverage and decide to apply for coverage at a later date, evidence of eligibility 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 Time Insurance Company.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, pharmacy or pharmacy-related facility, the Medical Information Bureau, consumer reporting agency, insurance or reinsurance company or employer, having information about me and/or my dependents to provide all such information as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to EMSI.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, pharmacy or pharmacy related facility, the Medical Information Bureau, consumer reporting agency, insurance or reinsurance company or employer, having information about me or my minor children to provide all such information as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to EMSI.

This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, blood disorder testing and treatment, lab data and EKGs. This information may also be disclosed to any medical records company engaged by Time Insurance Company, including but not limited to EMSI and its agents. Although

**SECTION I – AUTHORIZATION AND SIGNATURE** (continued)

federal regulation requires that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations.

Information regarding your eligibility will be treated as confidential. Time Insurance Company, or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its Members. If you apply to another bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address in the Bureau's information office is Post Office, Box 105, Essex Station, Boston, Massachusetts 02112, telephone number 617-426-3660.

I agree that a copy of this authorization will be valid as an original.

I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for Time Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Assurant Health, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization. I understand that Assurant Health markets products underwritten and issued by Time Insurance Company and that all references to Time Insurance Company in this authorization also includes Assurant Health.

This authorization expires upon the earliest of the following events: denial of my application, declination of enrollment, or, if insured, when I am no longer an insured of Time Insurance Company, but in no event will this authorization be in effect for longer than 24 months from date signed.

Any person who knowingly provides a statement or other information that is willfully false and/or fraudulently made with intent to defraud any insurance company or other person submits an enrollment form for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I understand that the agent submitting this enrollment form represents my interests, and those of Time Insurance Company. The agent has no right to bind coverage, to alter the terms of insurance coverage or enrollment form in any manner, or to adjust any claim for benefits. I, or my personal representative, have a right to receive a copy of this enrollment form.

Signature of Employee \_\_\_\_\_ Date \_\_\_\_\_

- PLEASE NOTE:**
- 1) Time Insurance Company is not responsible for enrollment forms not sent to us in a timely manner.
  - 2) Effective dates are subject to underwriting approval.
  - 3) Please retain a copy for your records.