ASSURANT Health®

ASSURANT SELF-FUNDED PROGRAM EMPLOYEE ENROLLMENT FORM

Instructions for completing this enrollment form

1) Each eligible employee enrolling for any coverage offered must complete the entire enrollment form except **Section B**. Section B 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 need to complete and sign the Waiver of Coverage in **Section E**.
3) If your employer offers multiple medical plans, please review the options with your employer.
4) Please print and complete in black ink.

Name of Employer: _____

Your Work Address: _____

SECTION A – EMPLOYEE INFORMATION

Employee's Name: _____
Last *First* *M.I.*

Employee's Mailing Address: _____
Street

_____
City *County* *State* *Zip*

Home Phone: (_____)_____ Work Phone: (_____) _____

E-mail Address: _____

By providing your email address you agree that you may receive your policy and/or certificate of issuance and other correspondence electronically.

Are you a U.S. Citizen or legal resident? ☐ Yes ☐ No Marital Status: ☐ Single ☐ Married

Full-time Employment Date: _____/ _____ / _____ Occupation/Job Title(s): _____

Hours worked per week for this employer: _____ Monthly Earnings: $_____

Current Status: ☐ Currently Working ☐ COBRA/Continuation through this employer ☐ Disability ☐ Retired ☐ Other Leave_____

Effective Date of COBRA/Continuation or Other Leave: _____ / _____ / _____

Earnings Basis: ☐ Salaried ☐ Hourly ☐ Commission

Employee Status: ☐ W2 ☐ 1099 ☐ Owner/Partner ☐ Other *(specify)*: _____

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

1. Group #: _____ Requested effective date: ____/____/____ (Subject to Underwriting approval)
   This enrollment is for *(check one)*: ☐ New Hire ☐ Adding Spouse/dependent child(ren)
   ☐ Special enrollment (must answer question 3) ☐ Annual open enrollment
   ☐ Coverage change *(specify)* _____

2. **Groups with multiple medical plans, indicate which plan you are requesting.* Medical Plan #:** _____
   **Please contact your employer for the plan options/descriptions which are identified on your employer's billing statement and/or quote.*

3. If enrolling outside of your employer's open enrollment period, indicate the reason (*documentation may be required*).
   a) ☐ Marriage ☐ Birth ☐ Adoption ☐ Court ordered (*copy of court order required*)
   For any event in 3a, list date of event ___/____/____
   b) ☐ Divorce/Separation ☐ Involuntary loss of coverage, state reason for loss _____
   ☐ COBRA/Continuation exhausted ☐ Other _____
   For any event in 3b, list coverage termination date ___/____/____

SECTION C – PERSONS TO BE COVERED
(Include yourself and all family members to be insured. If more space is needed, attach an additional sheet.)

☐ None ☐ Single: Employee only ☐ Employee & Spouse ☐ Employee & Children ☐ Family: Employee, Spouse & Children

(Include yourself and all family members to be insured) **Last Name** **First Name**	**Relationship & Gender**	**Date of Birth (Mo/Day/Yr)**	**Social Security Number**
	Employee ☐ Male ☐ Female	/ /	– –
	Spouse ☐ Male ☐ Female	/ /	– –
	Child ☐ Male ☐ Female	/ /	– –
	Child ☐ Male ☐ Female	/ /	– –
	Child ☐ Male ☐ Female	/ /	– –
	Child ☐ Male ☐ Female	/ /	– –
	Child ☐ Male ☐ Female	/ /	– –

Please explain if any child listed above is (a) not your natural child, legally adopted child or stepchild._____

_____

SECTION D – ADDITIONAL INSURANCE COVERAGE INFORMATION

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

   If "Yes", for whom? _____

   Please provide carrier and ID/Group number: _____
2. Are you, your spouse or any dependent children currently covered under Medicare Part A, B, or D? ..... ☐ Yes ☐ No

   If yes, will coverage remain active if the coverage for which you are applying is approved? ..... ☐ Yes ☐ No

SECTION E – WAIVER OF COVERAGE
(Complete and sign if waiving any or all coverages for self. Skip if enrolling for any coverages.)

All eligible employees must be listed as either enrolling or waiving coverage when first eligible.

Indicate the waiver reason below.

☐ **Individual Medical plan**	☐ **COBRA/Continuation**
☐ **Medicare/Medicaid**	☐ **Cost/Do not want**
☐ **Spouse's Employer plan**	☐ **Other:** _____
☐ **Tricare**	

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: _____

Printed Name:_____ **Date:** ____/____/____

Date of Full-time Employment: ____/____/____

SECTION F – MEDICAL HISTORY

	Height	Weight	Used any form of tobacco/nicotine in the last 12 months?
Employee			☐ Yes ☐ No
Spouse			☐ Yes ☐ No

For all "YES" answers to the following questions and all conditions checked below, provide full details in SECTION G on next page.

1. Have you or any of your dependents included on this enrollment form within the past *5 years* received treatment, testing, consulted with or received a diagnosis from a physician or provider for any of the following ***(If "Yes", check all that apply)***: ..... ☐ Yes ☐ No

- ☐ Acquired Immune Deficiency Syndrome (AIDS)
- ☐ Alcohol or Drug Use, Abuse, or Dependency
- ☐ Arthritis
  - ☐ Osteoarthritis ☐ Rheumatoid ☐ Other
- ☐ Asthma
- ☐ Back Disorders
- ☐ Blood Disorders
- ☐ Cancer or Tumor; Stage _____
  - ☐ Local (confined to the organ where it began)
  - ☐ Regional (spread to nearby lymph nodes/organs)
  - ☐ Distant/Metastasis (spread to distant organs)
- ☐ Chest Pain
- ☐ Digestive Disorders
  - ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Other
- ☐ Ear/Eye/Nose/Throat Disorders
- ☐ Endocrine Disorders
- ☐ Heart Disorders
  - ☐ Angioplasty ☐ Bypass
  - ☐ Heart Attack ☐ Other
- ☐ High Cholesterol/Triglycerides
- ☐ Hodgkin's/Lymphoma/Leukemia
- ☐ Human Immunodeficiency Virus (HIV) positive
- ☐ Hypertension/High Blood Pressure
- ☐ Immune Disorders
- ☐ Infertility
- ☐ Kidney Disorders
- ☐ Liver Disorder/Hepatitis
- ☐ Lupus
  - ☐ Discoid ☐ Systemic Lupus Erythematosus
- ☐ Mental, Nervous or Behavioral Disorders
  - ☐ Inpatient treatment ☐ Outpatient treatment
- ☐ Multiple Sclerosis (MS)
- ☐ Muscle Disorders
- ☐ Nervous System Disorders
- ☐ Paralysis
- ☐ Partial or Total Disability
- ☐ Physical Disorder or Deformity
- ☐ Reproductive Disorders
- ☐ Respiratory/Lung Disorders
- ☐ Seizures
- ☐ Sexually Transmitted Diseases
- ☐ Skeletal Disorders
- ☐ Stroke or Transient Ischemic Attack
- ☐ Thyroid Disorder
  - ☐ Hyperthyroidism ☐ Hypothyroidism
  - ☐ Other
- ☐ Transplant
  - ☐ Solid Organ ☐ Blood or Marrow
- ☐ Urinary Disorders
- ☐ Vascular Disorders

2. Have you or any of your dependents included on this enrollment form received treatment, testing, consulted with or received a diagnosis from a physician or provider for any of the following? ***(If "Yes", check all that apply)***: ..... ☐ Yes ☐ No

- ☐ Diabetes Mellitus / Date of onset ____/____/____ ☐ Pre-Diabetes ☐ Type I ☐ Type II
  - ☐ Diet controlled ☐ Oral Medications ☐ Insulin dependent ☐ Insulin Pump
- ☐ Diabetic Related Disorders
  - ☐ Heart disease
  - ☐ Kidney Impairments/Nephropathy
  - ☐ Nerve Impairments/Neuropathy
  - ☐ Peripheral Vascular disease
  - ☐ Stroke
  - ☐ Visual Impairments/Retinopathy

3. Have you or any of your dependents included on this enrollment form:

a. In the last *5 years* been diagnosed with or treated for any condition(s) not identified above? ..... ☐ Yes ☐ No

b. Been advised of the necessity or possibility of any future hospitalization, treatment, testing or surgery?... ☐ Yes ☐ No

4. Are you or any of your dependents included on this enrollment form currently pregnant? ..... ☐ Yes ☐ No

If yes,

a. Indicate due date ____/____/____

b. Is a Cesarean Section anticipated? ..... ☐ Yes ☐ No

c. Are multiple births expected? ..... ☐ Yes ☐ No

d. Are you/your dependent experiencing or anticipating any other complications? ..... ☐ Yes ☐ No

5. 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**

SECTION G – MEDICAL HISTORY DETAILS

(Details for all "YES" answers and all conditions checked in SECTION F, 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**

SECTION H – 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 coverage under the Assurant Self-Funded Program ("Program") 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 coverage.

I understand that (1) the answers given will be the basis of any coverage provided; (2) any material misrepresentation or failure to provide complete information to questions on this enrollment form may be used as a basis for changing rates or terminating coverage. (3) if coverage is not approved, I, my spouse and/or dependent children are not entitled to benefits; (4) 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 (5) 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, insurance company, pharmacy or pharmacy-related entity, pharmacy benefits manager (PBM) or PBM-related entity, 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, sickle cell 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 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.

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 dependents 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 include Assurant Health.

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

Any person who knowingly and with intent to defraud any insurance company or other person submits an enrollment form for coverage 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, not those of Time Insurance Company. The agent has no right to bind coverage, to alter the terms of 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.

********** NOTICE OF FEDERAL MANDATES **********

INITIAL NOTICE ABOUT SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your, or your dependents', other coverage).

You must, however, request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 and your dependents.

Effective April 1, 2009 a federal mandate took effect that allows for a Special Enrollment Period, which is outlined below.

A Special Enrollment Period will be provided for an employee and his/her dependent(s) who are eligible, but not enrolled, for coverage under the terms of our plan to enroll for coverage if either of the following conditions are met:

a) The employee or dependent is covered under a Medicaid plan or under a State child health plan and coverage of the employee or dependent under that plan is terminated as a result of loss of eligibility for coverage. The request for coverage under our group health plan must be submitted no later than 60 days following the date of termination of such prior coverage under Medicaid or a State child health plan.

b) The employee or dependent becomes eligible for assistance under a Medicaid plan or under a State child health. The request for coverage under our group health plan must be submitted no later than 60 days following the date of the employee or dependent is determined to be eligible for such assistance.

To request special enrollment, or to obtain more information, please contact our Customer Service Department at the numbers listed above.

NOTE: Additional state mandates may apply that would alter the contents of this notice, please see your certificate for more information.