



EMPLOYEE APPLICATION

APPLICATION MUST BE COMPLETED IN FULL AND TRUTHFULLY.

EMPLOYER INFORMATION
Employer Name: _____
Billing Division: _____

EMPLOYEE INFORMATION
Employee Name: _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Last First Initial </div>
Address: _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Number/Street </div>
City _____ State _____ Zip _____
SSN: _____ - _____ - _____ Phone Number () _____
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Birth Date: _____
Full-Time Date of Hire: _____ Normal hours worked per week _____
Occupation _____ Salary \$ _____ per _____ <small>(Only needed if disability or life insurance amount is by salary.)</small>
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow

WAIVING COVERAGE
Complete this section if you are NOT APPLYING for full coverage for yourself and your dependents.
I certify I was given the opportunity to apply for group benefits offered by my employer through Preferred United Plans of Michigan, and I do not accept the offer.
Waive Medical and Drug Coverage <input type="checkbox"/> Myself and Dependents <input type="checkbox"/> Spouse Only <input type="checkbox"/> Child(ren) Only
If you have elected to waive coverage for benefits shown above, please check one of the following boxes:
<input type="checkbox"/> I certify that I have other health coverage.
<input type="checkbox"/> I certify that I do not have other health coverage.

Underwritten by Companion Life Insurance Company
Administered by SecureOne Benefit Administrators, Inc.
www.secureoneinc.com



COVERAGE ELECTION

- Employee Only
- Family (Please complete dependent information below.)
- Employee Spouse
- Employee Child

DEPENDENT ENROLLMENT INFORMATION (Please check the appropriate box(es) and fill in the information below.)

Relationship	First Name	Last Name	Sex	DOB	SSN	Height/Weight
<input type="checkbox"/> Spouse						
<input type="checkbox"/> Natural/Adopted Child <input type="checkbox"/> Step-Child*						
<input type="checkbox"/> Natural/Adopted Child <input type="checkbox"/> Step-Child*						
<input type="checkbox"/> Natural/Adopted Child <input type="checkbox"/> Step-Child*						
<input type="checkbox"/> Natural/Adopted Child <input type="checkbox"/> Step-Child*						
<input type="checkbox"/> Natural/Adopted Child <input type="checkbox"/> Step-Child*						

*By including my step-child(ren) and signing this application, I verify that the above child(ren) is (are) primarily dependent upon me for care and financial support and living with me in a parent-child relationship. (Please include a copy of the step-child's birth certificate for our records.)

PLEASE NOTE: For children attending school who are age 19 through 25, please provide a copy of their full-time student schedule from the accredited college, university or educational institution. Without this, claims for this dependent may be delayed or denied.

OTHER INSURANCE INFORMATION

Do any of your above dependent(s) have other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
First and Last Name	Type(s) of other insurance	Insurance Carrier/ Address/Phone #	Policyholder's Name/ Date of Birth/Employer
	<input type="checkbox"/> Medical/Rx <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
	<input type="checkbox"/> Medical/Rx <input type="checkbox"/> Dental <input type="checkbox"/> Vision		

LIFE INSURANCE BENEFICIARY INFORMATION

Last Name	First Name	Initial	Relationship
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PRE-EXISTING DISCLOSURE

The terms of your group health plan include a pre-existing condition provision. This provision states that no benefits will be payable for conditions for which medical advice, diagnosis, care or treatment was recommended or received within 6 months prior to your enrollment date. This exclusion period may be for up to 12 months (18 months for late enrollees) after coverage begins. This limitation can be reduced by the amount of time of creditable coverage under previous health insurance. You and your dependents have the right to prove you had previous creditable coverage. You must receive a certificate of creditable coverage from your previous plan or insurer. Without this certificate, claims may be delayed or denied.

Have you had 12 months of creditable coverage (18 months if a late enrollee)? Yes No

Have your dependents had 12 months of creditable coverage (18 months if a late enrollee)? Yes No

PLEASE PROVIDE A COPY OF YOUR CERTIFICATE OF CREDITABLE COVERAGE. WITHOUT THIS CERTIFICATE, YOUR CLAIMS MAY BE DELAYED OR DENIED.



HEALTH QUESTIONS

The information collected on this form will be used by Preferred United Plans of Michigan to underwrite or classify the risks it may be assuming if your employer becomes a group policyholder. The information you provide will be retained by Preferred United Plans of Michigan and is strictly confidential. Please answer all questions.

Height _____ Weight _____

PLEASE ANSWER ALL QUESTIONS. Have you or any of your dependents been diagnosed, treated or told by a member of the medical profession that you have any of the following (if a "yes" answer is given, please circle condition(s)):

1. Amputation, Blood Vessel Disease, Arteriogram, Peripheral Vascular Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Chest Pain, Coronary Artery Disease, Heart Attack, Heart Failure, Heart Valve Disease, Irregular Heart Rhythm?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a Pacemaker or Defibrillator implanted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Alzheimer's, Dementia, Brain Injury, Brain Disorder, Neurosis, Depression, Psychosis, Seizures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Fainting, Unsteadiness, Paraplegia, Paralysis, Stroke, or Transient Ischemic Attack (TIA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Asthma, Emphysema, Chronic Obstructive Pulmonary Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Cirrhosis of Liver, Hepatitis, Crohn's Disease, Ulcerative Colitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Arthritis-Rheumatoid or Osteo/Degenerative, Osteomyelitis, Spinal Surgery, Back Disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Amyotrophic Lateral Sclerosis, Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Systemic Lupus Erythematosus, Lyme Disease,?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Blindness, Glaucoma, Blood or Immunological Disorders, AIDS or AIDS-related complex, Diabetes, Kidney Disease or Kidney Failure, Bone Marrow, Organ Transplant, Cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Alcohol or Substance Abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Any other injury, illness or condition not indicated above?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you or any of your dependents been hospitalized during the past 12 months? If yes, for what condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Are you or any of your dependents currently pregnant? If yes, what is the due date? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this a multiple pregnancy (twins, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Have you or any of your dependents had complications with a pregnancy in the past 3 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Are you or any of your dependents currently taking prescription drugs or have you or your dependents taken them within the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Do you have any pending test results (laboratory, radiology, etc.)? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please provide details below if you answered "Yes" to the questions 1-15 above.

#	Name	EE/SP/CH	Condition	Doctor Name/Phone #	Last Treatment

Please provide details below if you answered "Yes" to question 15 above.

Name	Condition	Medication	Dosage

"I declare that the information on this form is true to the best of my knowledge. I understand that anyone who knowingly submits an Enrollment Form or any Individual Underwriting Questionnaire form containing false information may be committing insurance fraud, which is a crime, and may result in immediate termination, legal action, or an adjustment of rates back to the original effective date.



SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse), because of other group health insurance, you may be able to enroll yourself or your dependents in this plan in the future, provided that you request enrollment within 30 days after the qualifying event. A qualifying event would include loss of coverage, through no fault of your own, marriage, birth, adoption, or placement for adoption. If coverage is waived without having other health insurance, and if you or your dependents choose to apply for coverage under the Preferred United Plans of Michigan at a later date, you will be treated as a late enrollee, unless you become eligible to enroll under this plan by reason of marriage, birth, adoption, or placement for adoption. If you are a late enrollee you, and your dependents, will be subject to an 18 month pre-existing condition limitation, instead of the standard 12 month pre-existing condition limitation.

ANNUAL OPEN ENROLLMENT PERIOD

You or your dependents may also enroll for group insurance benefits under Preferred United Plans of Michigan by submitting a completed enrollment form during an annual open enrollment period. The annual open enrollment period will begin 90 days before the group policy's anniversary date and will be for a period of 31 days. The Employer is responsible for advising all of its Employees of annual open enrollment periods.

AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION (PHI)

I understand that by law, health care providers, my employer, and Preferred United Plans of Michigan and other entities providing services in connection with Preferred United Plans of Michigan can use/disclose my individually identifiable health information for health care treatment, health care payment and health plan operations purposes subject to a minimum necessary standard. Notwithstanding, I specifically authorize ALL physicians, medical professionals and/or hospitals that I seek services from to give Preferred United Plans of Michigan, its legal representatives or its reinsurers, any information, record or knowledge of the health of the undersigned for underwriting purposes. This authorization includes confidential communicable disease related information, confidential HIV-related information, and information about drug and alcohol use. This authorization also includes information about psychiatric conditions, but does not provide for release of psychotherapy notes, which is defined as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of an individual's medical record. The following are not considered psychotherapy notes and thus may be produced: medication prescription and monitoring, counseling session start and stop time, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date. A photographic copy of this authorization shall be as valid as the original for 30 months from the date below. I know that I, or my authorized representative, may request and are entitled to receive a copy of this authorization. I authorize the use/disclosure of my individually identifiable health information by or to my spouse, my employer, any health care provider, Preferred United Plans of Michigan or any entity providing services in connection with the Preferred United Plans of Michigan in order to process my enrollment in Preferred United Plans of Michigan or process any claim for any Preferred United Plans of Michigan benefits.

PRE-NOTIFICATION

I understand the group insurance plan I am applying for contains pre-notification requirements for any inpatient or outpatient services.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent. I understand that Preferred United Plans of Michigan reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by contacting them. I understand that I have the right to restrict how Preferred United Plans of Michigan uses or discloses my protected health information to carry out payment or health operations; that Preferred United Plans of Michigan is not required to agree to the restrictions and; that Preferred United Plans of Michigan is bound by the restrictions to which it agrees. I have the right to revoke this consent by notifying Preferred United Plans of Michigan in writing, except to the extent that Preferred United Plans of Michigan has taken action in reliance on my consent. I understand that the information I consent Preferred United Plans of Michigan to receive may be re-disclosed and no longer protected by federal privacy regulations.

DISCLOSURES

I understand no insurance exists unless and until my employer receives notification in writing from Preferred United Plans of Michigan' office indicating coverage for my dependents and me is active and the effective date of the coverage. If, at any time prior to such notification, my dependents or I consults a doctor, is hospitalized, or has any change in health, I agree to inform Preferred United Plans of Michigan' office immediately.

I understand the agent does not have the authority to change or waive any of the provisions of this application, nor any of the provisions, terms or conditions or any other forms or materials supplied by Preferred United Plans of Michigan, nor bind Preferred United Plans of Michigan to any promises of coverage.

I am aware that I may be required to contribute toward the cost of my insurance premium as indicated by my employer. I ask my employer to deduct my portion of the premium for this insurance from my pay.

I understand I may be contacted by phone by Preferred United Plans of Michigan during its regular business hours to confirm/obtain information.

I/We have read the group enrollment application and have completed the sections that apply to my/our requirements.

Employee Signature _____ Date _____

Spouse Signature _____ Date _____

(Required whether or not spouse is covered.)

DO NOT WRITE IN THIS AREA

Group #: _____ Effective Date: _____

Coverage: EE FAM ES EC

Life Volume: _____

Type of Coverage: Medical/Rx STD Life Dep. Life

Term Date: _____ Reins. Date: _____ COBRA Start: _____

Rehire Date: _____ Term Date (2) : _____ COBRA End: _____

Date Completed: _____