



P.O. Box 2145
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(616) 454-4000 or (800) 876-7475
www.secureoneinc.com

APPLICATION MUST BE COMPLETED IN FULL OR YOUR CLAIMS MAY BE DELAYED OR DENIED.

EMPLOYER INFORMATION

Employer Name: _____

Employer Address: _____

Number/Street

City _____ State _____ Zip _____

EMPLOYEE INFORMATION

Employee Name: _____
Last First Initial

Address: _____

Number/Street

City _____ State _____ Zip _____

SSN: _____ - _____ - _____ Phone Number () _____

Sex: Male Female Birth Date: _____ Hire Date: _____

Occupation _____ Salary \$ _____ per _____

Marital Status: Single Married Divorced 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, and I do not accept the offer.

Waive Medical and Drug Coverage Myself and Dependents Spouse Only Child(ren) Only

Waive Dental Coverage Myself and Dependents Spouse Only Child(ren) Only

Waive Vision Myself and Dependents Spouse Only Child(ren) Only

Waive Other Coverage _____ Myself and Dependents Spouse Only Child(ren) Only

If I elect to waive coverage for benefits shown above, I certify do not certify that I am doing so because I have other health coverage.

COVERAGE ELECTION

- Employee Only
- Employee Spouse
- Family (Please complete dependent information below.)
- 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
<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 the limiting age indicated in your Plan Document, 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? Yes 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 _____

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 should have received a **certificate of creditable coverage** from your previous plan or insurer. If you did not get a certificate, you should request one from the previous plan or insurer.

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.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other group health insurance coverage, 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 a qualifying event. A qualifying event would include loss of coverage through no fault of your own, marriage, birth, adoption, or placement of adoption. If coverage is waived without having other health insurance, and if you or your dependents choose to apply for coverage under this Plan at a later date, you will be treated as a late enrollee. As such, you will not have special enrollment rights to enroll immediately and you will be subject to other late enrollee rules of the Plan.

ANNUAL OPEN ENROLLMENT PERIOD

You or your dependents may also enroll for group insurance benefits under this Plan by submitting a completed enrollment form during an annual open enrollment period. The annual open enrollment period will begin as designated by the Employer once every Calendar Year 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 RELEASE MEDICAL INFORMATION

I understand that by law, health care providers, my employer, and SecureOne and other entities providing services in connection with the Plan 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 the Insurance Company and SecureOne Benefit Administrators, Inc., 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 the individually identifiable health information of myself and my minor dependents by or to my spouse, my employer, any health care provider, SecureOne or any entity providing services in connection with the Plan in order to process my enrollment in the Plan or process any claim for any Plan 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 SecureOne 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 SecureOne uses or discloses my protected health information to carry out payment or health operations; that SecureOne is not required to agree to the restrictions and; that SecureOne is bound by the restrictions to which it agrees. I have the right to revoke this consent by notifying SecureOne in writing, except to the extent that SecureOne has taken action in reliance on my consent.

DISCLOSURES

I understand no insurance exists unless and until my employer receives notification in writing from SecureOne Benefit Administrators, Inc.'s 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 SecureOne Benefit Administrators, Inc.'s 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 the Plan or SecureOne Benefit Administrators, Inc., nor bind the Plan 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 SecureOne Benefit Administrators, Inc. on behalf of the Plan during the regular business hours of SecureOne Benefit Administrators, Inc. 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 _____

DO NOT WRITE IN THIS AREA

Group # _____ Effective Date _____

Coverage: EE FAM ES EC

Life Volume: _____ Supp. Life: _____ Dep. Life _____

Type of Coverage: STD Medical Rx Dental Vision Hearing

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

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

Date Completed: _____