



PO Box 1847
Grand Rapids, MI 49501-1847
1-800-675-1233

Underwritten by US Health and Life Insurance Company
Administered by SecureOne Benefit Administrators, Inc.

www.secureoneinc.com

A. Employee Information This section must be completed

New Enrollment Active Retired COBRA Change Request Male Female Single Married

Employee Name: (First) (M.I.) (Last)

Employee Address

City: State: Zip:

Date of Birth: SSN: Occupation:

Daytime Phone Number: Height: Weight:

Employer Name: Date of Hire: Class or Salary:

COBRA Qualifying event: COBRA Event Date:

Life Insurance: Beneficiary Name: Relationship:

B. Dependent Information This section must be completed when enrolling your dependents

Are you enrolling your eligible spouse and dependents? Yes No If yes, please complete the following:

\*Dependents enrolling with a different last name must provide proof of dependency (copy of adoption form, birth certificate, tax return or marriage license)

Table with 8 columns: First Name, Initial, Last Name, Relationship, Date of Birth, Sex, Height/Weight, Social Security Number

If any dependents (other than spouse) listed above are full-time students 21 or older, please complete the following additional information along with a current Student Verification Form, copy of current transcript or student enrollment form.

Table with 4 columns: Name of Dependent, Name of School, School Address, Number of Credit Hours

C. Change Request

Please complete if requesting any changes to coverage. Requested Change Date:

Change Beneficiary to:

Add Dependents: Yes No If yes, please complete Section B, C, and if applicable E.

Remove Dependents: Yes No If yes, please complete Section B & C. Explain

Change of Address: Yes No If yes, please indicate new address in Section A.

Change Name to:

Date of Marriage: Date of Divorce:

D. Other Medical Insurance Information This section must be completed

During the next year will you or your dependents be covered under another policy or spouse's medical insurance? Yes No

If yes, list those covered:

Is anyone on Medicaid? Yes No If yes, please provide the dependent's name and effective date:

Is anyone on Medicare? Yes No Effective date: Part A Part B

Reason for Medicare eligibility: Over 65 Disabled Kidney Disease

**E. Waiver**

**This section must be completed if declining to enroll**

I decline to enroll for this coverage for myself, my spouse, and my dependent children due to:

Spousal coverage     Existence of other health coverage     Other reason (explain): \_\_\_\_\_

**Check one of the above boxes, then read and sign.**

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage will be subject to treatment as a late enrollee and I may only apply at the next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such other health coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependent provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption. I have read and understand the "Important Information" located on the back of this form.

**Employee**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Sign here If you are declining coverage)

**F. Medical History**

**Only complete this section if enrolling for coverage**

Have you or your dependents been diagnosed, treated, received counseling or advice during the past 5 years for any of the following: PLEASE CHECK AND EXPLAIN ALL THAT APPLY. USE AN ADDITIONAL PAGE IF NEEDED.

**Cancer/Tumor**     Lung     Breast     Liver     Colon     Leukemia/Lymphoma     Melanoma     Prostate  
 Other: \_\_\_\_\_

Yes  No    Patient name: \_\_\_\_\_ Date Diagnosed: \_\_\_\_\_ Treatment: \_\_\_\_\_  
Date Last Treated: \_\_\_\_\_ Current Status: \_\_\_\_\_ Stage/Level: \_\_\_\_\_

**Heart/Circulatory**     Varicose Veins     Skin Ulcer     Phlebitis     Stroke     Aneurysm     Blood Disorder     Hemophilia  
 Heart Disease     Bypass/Angioplasty (# of vessels involved) \_\_\_\_\_     Congestive Heart Failure

Yes  No     High Blood Pressure (Last 3 Readings & dates of Readings) \_\_\_\_\_  
 High Cholesterol (Most recent reading & date of reading) \_\_\_\_\_

Patient name: \_\_\_\_\_ Date Diagnosed: \_\_\_\_\_ Treatment: \_\_\_\_\_  
Date Last Treated: \_\_\_\_\_ Current Status: \_\_\_\_\_

**Reproductive**    Current pregnancy (Due date:) \_\_\_\_\_  Multiples Expected \_\_\_\_\_  Pregnancy Complications (current or past)  
 Infertility     Endometriosis     Breast Disorders     Other \_\_\_\_\_

Yes  No    Patient name: \_\_\_\_\_ Date Diagnosed: \_\_\_\_\_ Treatment: \_\_\_\_\_  
Date Last Treated: \_\_\_\_\_ Current Status: \_\_\_\_\_

**Intestinal/Endocrine**     Gallbladder     Liver Disorder     Hepatitis B/C     Colon Disorder (provide diagnosis)     Thyroid Disorder  
 Crohn's/Ulcerative Colitis     Diabetes     Ulcer     Chronic Pancreatitis     Hiatal Hernia/GI Reflux  
 Last Hemoglobin A1C \_\_\_\_\_     Fasting Blood Sugar \_\_\_\_\_     Other \_\_\_\_\_

Yes  No    Patient name: \_\_\_\_\_ Date Diagnosed: \_\_\_\_\_ Treatment: \_\_\_\_\_  
Date Last Treated: \_\_\_\_\_ Current Status: \_\_\_\_\_

**Brain/Nervous**     Multiple Sclerosis     Paralysis     Cerebral Palsy     Migraines     Parkinson's Disease     Alzheimer's Disease  
 Epilepsy (Type & Date of last seizure) \_\_\_\_\_     Other \_\_\_\_\_

Yes  No    Patient name: \_\_\_\_\_ Date Diagnosed: \_\_\_\_\_ Treatment: \_\_\_\_\_  
Date Last Treated: \_\_\_\_\_ Current Status: \_\_\_\_\_

**Immune**     Lupus     HIV+     AIDS     Other: \_\_\_\_\_

Yes  No    Patient name: \_\_\_\_\_ Date Diagnosed: \_\_\_\_\_ Treatment: \_\_\_\_\_  
Date Last Treated: \_\_\_\_\_ Current Status: \_\_\_\_\_

**F. Medical History, Continued****Only complete this section if enrolling for coverage**

**Lungs/Respiratory**    Asthma   Allergies   Cystic Fibrosis   Emphysema/Chronic Bronchitis   Pneumonia   Tuberculosis   Sleep Apnea  
Other: \_\_\_\_\_  
Patient name: \_\_\_\_\_ Date Diagnosed: \_\_\_\_\_ Treatment: \_\_\_\_\_  
Yes   No    Date Last Treated: \_\_\_\_\_ Current Status: \_\_\_\_\_

**Eyes/Ears/Nose/Throat**    Retinopathy   Cleft lip/palate   Chronic Sinusitis   Deviated Septum   Acoustic Neuroma   Glaucoma   Cataracts  
Chronic ear infections   Other: \_\_\_\_\_  
Patient name: \_\_\_\_\_ Date Diagnosed: \_\_\_\_\_ Treatment: \_\_\_\_\_  
Yes   No    Date Last Treated: \_\_\_\_\_ Current Status: \_\_\_\_\_

**Urinary/Kidney**    Renal Failure   Polycystic Kidney Disease   Neurogenic Bladder   Kidney Stones   Prostate Disorder  
Other: \_\_\_\_\_  
Patient name: \_\_\_\_\_ Date Diagnosed: \_\_\_\_\_ Treatment: \_\_\_\_\_  
Yes   No    Date Last Treated: \_\_\_\_\_ Current Status: \_\_\_\_\_

**Bones/Muscles**    Bulging/Herniated Disc   Pituitary Dwarfism   Spina Bifida   Arthritis (rheumatoid or Osteo)   Joint Injury  
Pulled/Strained muscles   Other Back/Neck Disorders   Other: \_\_\_\_\_  
Patient name: \_\_\_\_\_ Date Diagnosed: \_\_\_\_\_ Treatment: \_\_\_\_\_  
Yes   No    Date Last Treated: \_\_\_\_\_ Current Status: \_\_\_\_\_

**Mental Health/Substance Abuse**    Bipolar/Manic Depression   Eating Disorder   Anxiety/Depression   Alcoholism   Drug Abuse  
Suicide Attempt   Attention Deficit Disorder   Other: \_\_\_\_\_  
Patient name: \_\_\_\_\_ Date Diagnosed: \_\_\_\_\_ Treatment: \_\_\_\_\_  
Yes   No    Date Last Treated: \_\_\_\_\_ Current Status: \_\_\_\_\_

**Transplant**    Organ \_\_\_\_\_   Bone Marrow   Surgery Completed (date:) \_\_\_\_\_  
Discussed possible future transplant  
Patient name: \_\_\_\_\_ Current Treatment: \_\_\_\_\_  
Yes   No    Date Last Treated: \_\_\_\_\_ Current Status: \_\_\_\_\_

**Medication**    Current Medications

<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication	Daily Dosage	Frequency
	Member/Dependent Name: _____		
	Member/Dependent Name: _____		
	Member/Dependent Name: _____		
	Member/Dependent Name: _____		
	Member/Dependent Name: _____		

**Other**    Treatment or surgery discussed or advised, but not yet done   Abnormal test or physical results  
Condition or Congenital Disorder not mentioned above   Unexplained Weight Change  
Yes   No    Patient name: \_\_\_\_\_ Date: \_\_\_\_\_  
Details: \_\_\_\_\_

Yes   No    Has anyone on this application smoked or used tobacco products during the past 12 months? If yes, indicate the number of packs per day along with the number of years.  
Name: \_\_\_\_\_ Packs/Day: \_\_\_\_\_ Years: \_\_\_\_\_

Yes   No    Do you drink alcohol socially, daily or not at all? \_\_\_\_\_ Type of Alcohol: \_\_\_\_\_

Please give the name and telephone number of your current doctor/doctors.

Patient	Doctor	Number

**G. Employee Agreement/Authorization to Release HIPAA Medical Information This section must be completed**

Agreement: I apply to US Health and Life Insurance Company for coverage. I declare that all of the statements contained in this enrollment form, to the best of my knowledge, are true and correct, and that no material insurance information has been withheld or omitted concerning the past or present state of health of myself or of my named dependents. I understand that the above answers shall be the basis for the insurer to issue a certificate of insurance. I understand and agree that the insurer is not bound by any statement made by or to any agent unless documented in this enrollment form. I understand that any misstatements about medical history could result in denial of an otherwise valid claim and voiding or reformation of insurance.

I acknowledge reading the entire completed enrollment form and the insurance agent has explained the coverages, limitations and exclusions, other details of coverage of the insurance applied for, and the underwriting rules and regulations of the insurer. No agent has authority to bind or alter coverage.

I have read the notice explaining the use of the Medical Information Bureau. I authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau, or Consumer Reporting Agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and or HIV/AIDS test results or diagnosis and/or treatment of me or my named dependents and other non-medical information of me or my named dependents, to give to US Health and Life Insurance Company or its legal representative, any and all such information.

I understand the information obtained by use of this authorization will be used by the insurer to determine eligibility for insurance, and eligibility for benefits under any existing policy, for myself and my named dependents. Any information obtained will not be released by the insurer to any persons or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my application for insurance, for any claims, or as may be otherwise lawfully required or as I may further authorize.

*I understand that I may request a copy of this authorization at anytime.*

US Health and Life Insurance Company, like other health insurance companies, sometimes evaluates present and past medical history of applicants to determine their eligibility for certain policies.

With US Health and Life Insurance Company, this evaluation is limited to specific insurance policies; and the applications for those clearly show this requirement.

I authorize the use and disclosure of my protected health information as described below.

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

US Health and Life Insurance Company is authorized to use or disclose my protected health information. My protected health information will be used or disclosed only for the purposes of administering the insurance certificate subject of this application.

I understand that if I refuse to sign this authorization that US Health and Life Insurance Company may refuse to enroll me or determine that I am not eligible for benefits.

I understand that I may revoke this authorization at any time by sending a written notification to US Health and Life Insurance Company at 8220 Irving Road, Sterling Heights, MI 48312, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (i) for information that US Health and Life Insurance Company already has used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition of coverage.

Any information you give USHL or its insurer regarding your insurability will be treated strictly confidential. USHL, or its insurer, may make a brief report on information received with your application to the Medical Information Bureau. (A nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. P.O. Box 105, Essex Station, Boston, MA 02112. Phone: 617 426-3660). The Bureau, upon request from a member company to whom you may apply for insurance or to whom a claim for benefits may be submitted, will supply the company with such information. If you ask, the Bureau will arrange disclosure of the information in your file and you may seek to correct any inaccuracy in accordance with the Fair Credit Reporting Act procedures.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

US Health and Life Insurance Company  
8220 Irving Road  
Sterling Heights, MI 48312

Administered by SecureOne Benefit Administrators, Inc.

**DO NOT WRITE IN THIS AREA**

Group # \_\_\_\_\_ Effective Date \_\_\_\_\_

Coverage: \_\_\_\_\_

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

Term Date: \_\_\_\_\_ Reins. Date: \_\_\_\_\_ COBRA Start: \_\_\_\_\_

Rehire Date: \_\_\_\_\_ Term Date (2) : \_\_\_\_\_ COBRA End: \_\_\_\_\_