Preferred United Plans®
"Alternative Funding"

Employee Health Questionnaire (1)

SECUREONE℠ Benefit Administrators, Inc.

SECTION I - EMPLOYER INFORMATION

Employer Name: _____

Address: _____City_____State_____ Zip_____

Director of HR: _____ Phone: (_____) _____

E-Mail:_____ Fax: (_____) _____

EMPLOYEE INFORMATION

Employee Name: _____ ☐ Male ☐ Female
Last First Middle Initial

Date Of Birth:_____/_____/_____ Social Security #:_____-_____-_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address:_____
Number/Street

City_____ State_____ Zip_____ Phone#(____)_____

Full-Time Date of Hire:_____ Normal # of hours worked per week _____

Occupation _____

APPLICATION INTENTIONS

Coverage Type/ Medical & Rx	APPLYING for coverage for: ☐ Employee ☐ Spouse ☐ Children	WAIVING for coverage for: ☐ Employee ☐ Spouse ☐ Children

If you have elected to waive coverage for benefits shown above, please check one of the following boxes:

☐ I certify that I have other health coverage. ☐ I certify that I do NOT have other health coverage.

	Spouse ☐ M ☐ F	Child 1 ☐ M ☐ F	Child 2 ☐ M ☐ F	Child 3 ☐ M ☐ F	Child 4 ☐ M ☐ F	Child 5 ☐ M ☐ F
First Name:						
Middle Initial:						
Last Name:						
Date of Birth:						
Height & Weight:						
SSN:						

SECTION II – OTHER INSURANCE INFORMATION – Do any of your above dependent(s) have other insurance? ☐ Yes ☐ No				
First & Last Name	Type(s) of other insurance	Current Insurance Carrier/Address/Phones#	Policyholder's Name/Date of Birth/Employer	Will the coverage you are applying for now be primary? Yes or No*
	☐ Medical/Rx			
	☐ Medical/Rx			
	☐ Medical/Rx			
	☐ Medical/Rx			
	☐ Medical/Rx			
*If dependents are covered under a policy by ex-spouse, please submit the full, final signed copy of the divorce decree.				

SECTION III – LIFE BENEFICIARY INFORMATION

MUST BE COMPLETED ON EVERY APPLICATION EVEN IF WAIVING MEDICAL/RX COVERAGE

Primary Beneficiary:

Name:_____ Relationship:_____

Soc. Security Number: _____ Date of Birth: _____

Contingent Beneficiary:

Name:_____ Relationship:_____

Soc. Security Number: _____ Date of Birth: _____

LIFE INSURANCE IS MANDATORY UNDER THE PREFERRED UNTIED PLANS® "ALTERNATIVE FUNDING". ALL FULL TIME EMPLOYEES WAIVING MEDICAL AND PRESCRIPTION DRUG COVERAGE MUST TAKE THE MINIMUM LIFE INSURANCE VOLUME OF $15,000

Preferred United Plans®
"Alternative Funding"

Employee Health Questionnaire Continued (3)

SECUREONE℠
Benefit Administrators, Inc.

SECTION IV - HEALTH QUESTIONS - *ALL QUESTIONS MUST BE ANSWERED*

Information collected on this form is being used by Preferred United Plans® "Alternative Funding"/SecureOne Benefit Administrators self-funded program to evaluate the underwritten cost to the plan your employer has selected as possible health care coverage. The information being provided will be retained only by the entities officially assigned with Preferred United Plans® "Alternative Funding" self-funded program.

Employee Height: _____ Employee Weight: _____ Spouse Height: _____ Spouse Weight:_____

In the past 5 years have you or any person applying for coverage been diagnosed with, advised of, had or been in need or treatment or surgery for any conditions related to the following questions below. (if a "yes" answer is given, please circle conditions(s)):

1.	Are you or any immediate family member pregnant or an expectant parent or in the process of adoption, whether or not that person is listed on this application? If yes, what is the expected due date?_____	☐ Yes ☐ No
	If pregnant, any complications with past pregnancies?	☐ Yes ☐ No
	Is this a multiple pregnancy (twins, etc.)?	☐ Yes ☐ No
2.	Any heart or circulatory system disorders including high blood pressure, high cholesterol, anemia, clogged arteries, atherosclerosis, heart attack, chest pain, stroke, TIA, heart valve disorder, irregular heartbeat, pacemaker, heart murmur, atrial fibrillation, angioplasty, heart bypass surgery, atrial septal defect, aortic insufficiency, congestive heart failure, cardiomegaly, cardiomyopathy, aneurysm, bleeding, or clotting disorder, hemophilia, varicose veins, or heart transplant?	☐ Yes ☐ No
3.	Any respiratory system disorders including lung disease, emphysema, asthma, chronic cough, tuberculosis, cystic fibrosis, chronic obstructive pulmonary disease (COPD), bronchitis, pneumonia, or lung transplant?	☐ Yes ☐ No
4.	Any digestive system disorders including disease of the pancreas, liver or gallbladder, hepatitis, cirrhosis, fatty liver, gastric bypass or banding, eating disorders, GERD, Crohn's disease, gastrointestinal disorder, ulcer, ulcerative colitis or liver or pancreas transplant?	☐ Yes ☐ No
5.	Any musculoskeletal system disorders including back, spine or neck disorders, arthritis, hip, or knee replacement, amputation or prosthesis, lupus, fibromyalgia, or connective tissue disorder?	☐ Yes ☐ No
6.	Any nervous system or mental disorders including psychoses, depression, anxiety, epilepsy, seizure, multiple sclerosis, muscular dystrophy, myasthenia gravis, paralysis, Parkinson's disease, cerebral palsy, schizophrenia, bipolar/manic depressive disorder, senile dementia, Alzheimer's, or amyotrophic lateral sclerosis (ALS/Lou Gehrig's disease)?	☐ Yes ☐ No
7.	Any endocrine and metabolic system disorders including diabetes, elevated blood sugar or presence of any protein, albumin or sugar in the urine, thyroid, adrenal or pituitary disorders?	☐ Yes ☐ No
8.	Any genital, reproductive or urinary system disorders including blood in urine, infertility, irregular menstruation, ovary disorder, abnormal PAP, cystitis, stones, prostate disorder, sexually transmitted disease, complications of pregnancy (Including caesarean section), kidney stones or disease, end state renal disease (ESRD), kidney transplant or dialysis?	☐ Yes ☐ No
9.	Any tumors, cysts, birth defects or congenital abnormalities including cleft lip or palate, autism, Down's Syndrome, congenital heart defect, mental retardation, or other physical deformities?	☐ Yes ☐ No
10.	Any acquired immune deficiency syndrome disorder (AIDS), chronic fatigue, AIDS-related complex (ARC) or ever tested positive for the human immunodeficiency virus (HIV+)	☐ Yes ☐ No
11.	Any cancers, including melanoma, leukemia, Hodgkin's disease, lymph glands/node, bone marrow or stem cell transplant?	☐ Yes ☐ No
12.	Any eyes and ears disorders including glaucoma, retinopathy, cataract, corneal transplant, or loss of hearing?	☐ Yes ☐ No
13.	Any tobacco or nicotine products used in the last 12 months?	☐ Yes ☐ No
14.	Any alcoholism or alcohol abuse, drug use including cocaine, heroin and narcotics, chemical dependency or recommended for drug or alcohol counseling or driving while intoxicated (DUI)?	☐ Yes ☐ No
15.	Any medical or physical impairment or take any medications or receive medical treatment for any conditions not already mentioned?	☐ Yes ☐ No
16.	Any testing, surgery, treatment, therapy, medications, or hospitalization recommended or advised and not yet completed?	☐ Yes ☐ No
17.	Any history of breast implants or internal fixations (plates, screws, pins, shunts, stents, etc.)?	☐ Yes ☐ No
18.	Are you or any of your dependents currently taking prescription drugs or have you or your dependents taken them within the last 24 months? If yes, please list below.	☐ Yes ☐ No

Please provide details below if you answered "Yes" to the question 1-17 above.

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

Please provide details below if you answered "Yes" to question 18 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 a Preferred United Plans® "Alternative Funding" Health Risk Assessment Application containing false information is committing fraud, which is a crime. Preferred United Plans "Alternative Funding" has the legal right to seek damages, terminate coverage for the individual or the employer's plan."

Employee Statement and Signature

I hereby: Request enrollment in the self-funded Preferred United Plans® "Alternative Funding" established and maintained by my employer (Employer) for its eligible employees and their eligible dependents; Represent that I am an eligible employee of the Employer; Represent that my statements and answers to the questions in this enrollment form are true and complete to the best of my knowledge and belief; and Authorize the Employer to deduct any required Plan contribution from my earnings. I **FURTHER ACKNOWLEDGE AND UNDERSTAND THIS IS NOT AN INSURED BENEFIT PLAN;** All Plan benefits are self-funded (self-insured) by the employer; The Employer is solely responsible for all benefit payments; Coverage is not effective until the Plan approves this enrollment form; Plan benefits are available only if a person is covered under and all required contributions for such coverage have been received by the Plan; If I have waived coverage for a dependent, I also waive all claims under the Plan for benefits for that dependent, and if I decide to enroll that person at a later date, the effective date for my dependent may be delayed; A full description of the medical expense benefits under the Plan appears in Plan Document; The agent submitting this enrollment lacks authority to change the enrollment form, approve Plan coverage, alter Plan terms or adjust claims; the Employer has delegated certain non-fiduciary, ministerial administrative acts, duties and responsibilities of the Plan to SecureOne Benefit Administrators, Inc. a licensed third-party administrator; However, the Sponsoring Employer remains the Plan Sponsor, Plan Fiduciary, Plan Administrator and Plan Trustee and is responsible for all coverage determinations and benefit payments. SecureOne Benefit Administrators, Inc. does not insure the Plan and is not responsible for funding benefit payments; My statements and answers in this enrollment form will be the basis for approving Plan coverage and any material misrepresentation or omission may result in an increase in Plan contribution rates or termination of my coverage; Any person who knowingly and with intent to defraud, submits and enrollment form or files a claim containing a materially false statement or omitting materially false information may be found guilty of fraud in a court of law, which if found guilty, may be terminated from the Plan, re-evaluation of rates to the employer or be reimbursed of all claims paid under the illegal act.

ANNUAL OPEN ENROLLMENT PERIOD: You or your dependents may also enroll for group insurance benefits under Preferred United Plans® "Alternative Funding" employer sponsored self-funded plan by submitting a completed enrollment form during an annual open enrollment period. The annual open enrollment period will begin 30 days before the group's renewal 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.

SPECIAL ENROLLMENT RIGHTS: If you acquire a new dependent by marriage, birth, adoption or placement for adoption, he/she may be able to enroll without delay or penalty if you request enrollment within 31 days (of the marriage, birth, adoption or placement for adoption); If you decline enrollment for any dependent (including your spouse) because of other health plan or group insurance coverage and that dependent subsequently becomes ineligible for the other coverage (or the employer stops contributing towards that coverage) he/she may be able to enroll without delay or penalty, if you request enrollment within 31 days of ineligibility or termination of employer contributions; If you decline enrollment for any dependent (including your spouse because of coverage under Medicaid or a State child health plan, and that dependent's coverage is subsequently terminated due to ineligibility, he/she may be able to enroll without delay or penalty, if you request enrollment within 60 days of the termination for coverage; If you decline enrollment for any dependent (including your spouse) and that dependent subsequently becomes eligible for a premium assistance subsidy from Medicaid or a State child health plan, he/she may be able to enroll without delay or penalty, if you request enrollment within 60 days of eligibility for the subsidy. To request special enrollment, contact the Employer or SecureOne Benefit Administrators, Inc. at 800-876-7475.

PERSONAL INFORMATION NOTICE: As required by law, this notice is intended to inform you that 1) Personal information may be collected from third parties; 2) Such information as well as other personal or privileged information collected by the health plan or its legal representative may be in certain instances as prescribed by law, disclosed to other third parties without your prior authorization; 3) You have the right to access and correct the collected information; 4) Your right to access does not include any information which relates to and is collected in connection with, or in reasonable anticipation of a claim or civil or criminal proceeding; 5) We will provide a more detailed notice of information practices upon request.

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize the disclosure of all nonpublic personal information and individually identifiable protected health information for me (and my dependent(s), if applicable), including by not limited to employment status, other health plan coverage, diagnosis, prognosis, medical treatment or care and physical or mental conditions (including alcohol or drug dependency), by any physician, medical practitioner, hospital, other medical related facility, insurance company, employer or benefit plan having such information, to the health plan or it's legal representative, agent or vendor, for the purpose of processing enrollment and may request a copy of this authorization; that enrollment by not the processing of claims, is condition on my signing this authorization; that this authorization will be used as its own document, separate from the enrollment form; that a photocopy of this authorization may be re-disclosed and may no longer be covered by federal or state privacy laws and that I have the authority to act as the personal representative of my dependent(s) (if requesting dependent coverage).

PRE-NOTIFICATION: I understand that the self-funded group health plan I am applying for contains pre-notification requirement for any inpatient or outpatient services.

DISCLOSURES: I understand no coverage exists unless and until my employer receives notification in writing from Preferred United Plans "Alternative Funding"/SecureOne Benefit Administrators, Inc. 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 "Alternative Funding"/SecureOne Benefit Administrators Inc. 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 "Alternative Funding", nor bind Preferred United Plans "Alternative Funding"/SecureOne Benefit Administrators, Inc. 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 contribution for this coverage from my pay.

I understand I may be contacted by phone by Preferred United Plans "Alternative Funding"/SecureOne Benefit Administrators, Inc. during its regular business hours to confirm/obtain information.

I verify that the child(ren) listed on the application are the Employee's own blood descendent of the first degree or lawfully adopted child, a covered Employee's child who is a recipient under the Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, and/or any other child for whom the Employee has obtained legal guardianship.

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

Employee Signature_____ Date_____

DO NOT WRITE IN THIS AREA

Group #: _____ Effective Date: _____ Coverage: ☐ EE ☐ FAM ☐ ES ☐ EC Life Volume:_____

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

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

Rehire Date: _____ Term Date (2) : _____ Date Completed:_____