National General Benefits Solutions

Employee Enrollment Form

EMPLOYER INFORMATION (must be completed)	
Company Name/DBA:	Company Address:

You must complete this form in its entirety in order for you or your dependents to be covered under the health insurance plan. If you are waiving coverage for yourself or your dependents, it must be clearly indicated on this form. If you do not complete this form in its entirety for yourself or your dependents at least 5 business days prior to the effective date, you or your dependents may not be eligible for coverage until the next open enrollment period.

TO BE COMPLETED BY EMPLOYEE (if applying or waiving coverage)	
BENEFIT PLAN:	GROUP NUMBER:

A - EMPLOYEE (Primary Applicant)

Name (Last, First, MI):

Social Security Number:	Gender: ☐ M ☐ F	Birth Date (mm/dd/yyyy):	**Average number of hours worked per week?**	**Date full-time employment started: (mm/dd/yyyy)**
Home Street Address		City	State	Zip
Home Phone: Cell Phone:		Work Phone Best Time to Call:	Email Address: **Job Title**:	

Status: ☐ Single ☐ Married Employee Status: ☐ W2 ☐ 1099 ☐ Owner/Partner	Check One: ☐ Full-Time ☐ Part-Time ☐ Retiree ☐ COBRA ☐ Cal-COBRA COBRA effective date(mm/dd/yyyy) _____	Earnings Basis: ☐ Salaried ☐ Hourly ☐ Commission

NEW ENROLLMENT or WAIVER, please check one:

☐ New Hire ☐ Qualifying Life Event:_____Date: (mm/dd/yyyy) _____
☐ Re-hire ☐ COBRA
☐ Open Enrollment ☐ Waiver of Coverage (complete section B)
☐ New Group ☐ Other: _____

B - WAIVER OF COVERAGE – DO NOT COMPLETE IF ENROLLING FOR COVERAGE

Complete and sign if waiving any or all coverages for self. All eligible employees must be listed as either enrolling or waiving coverage when first eligible.

Indicate the waiver reason below.

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

Neither I nor my dependents have been induced or pressured to decline coverage by my employer, the agent, or National Health Insurance Company. I and my dependents have waived such coverage of our own accord.

Signature:	Date:
Printed Name:	Date full-time employment started:

C – ONLY TO BE COMPLETED BY ADDITIONS TO EXISTING GROUPS OR FOR CHANGES TO EXISTING COVERAGE

Requested effective date: / / (Subject to Underwriting approval)

1. Groups with multiple medical plans, indicate which plan you are requesting.* Medical Plan #:_____
2. If dental coverage offered, are you electing? ☐ Yes ☐ No If yes, list those enrolling_____
   If multiple dental plans are offered, which plan are you requesting? * Dental Plan _____
3. If vision coverage offered, are you electing? ☐Yes ☐ No If yes, list those enrolling_____

**Please contact your employer for the plan options/descriptions which are identified on your employer's billing statement and/or quote.*

4. 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 a, list date of event / /

   b) ☐ Divorce/Separation ☐ Involuntary loss of coverage, state reason for loss_____(proof required)
   ☐ COBRA/Continuation exhausted ☐ Other

For any event in b, list coverage termination date / /

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

☐ Employee Only	☐ Employee Spouse	☐ Employee Child(ren)	☐ Family: Employee, Spouse, & Child(ren)	
Include yourself & all family members to be insured **Last Name** **First Name**		**Relationship & Gender**	**Date of Birth (MM/DD/YYYY)**	**Social Security Number**
		Employee ☐ M ☐ F	XXXXXX	XXXXXX
		Spouse ☐ M ☐ F		
		Child ☐ M ☐ F		
		Child ☐ M ☐ F		
		Child ☐ M ☐ F		
		Child ☐ M ☐ F		
		Child ☐ M ☐ F		

E – ADDITIONAL INSURANCE COVERAGE INFORMATION

1. Will any current medical plan remain active if coverage is approved?	☐ Yes ☐ No
a) If "Yes", for whom? b) 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

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

Complete all questions below and check all that apply in Question 1. Complete Section G on the next page by providing complete details for each Yes answer and for all conditions checked in Question 1.

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?.....☐ Yes ☐ No

☐ AIDS or HIV
☐ Alcohol or Drug Use, Abuse, or Dependency
☐ Arthritis or other Skeletal Disorder
  ☐ Osteoarthritis ☐ Rheumatoid
  ☐ Other
☐ Back Disorders
  ☐ Chiro ☐ Sprain/strain
  ☐ Surgery ☐ Other
☐ Blood Disorders (including anemia)
☐ 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
☐ Diabetes Mellitus Date of onset____/____/____
  ☐ Pre-Diabetes ☐ Diet Controlled
  ☐ Type I ☐ Type II
  ☐ Insulin Dependent ☐ Insulin Pump
☐ Diabetic Related Disorders
  ☐ Heart disease ☐ Nephropathy
  ☐ Neuropathy ☐ Peripheral Vascular Disease
  ☐ Retinopathy ☐ Stroke
☐ Digestive Disorders
  ☐ Crohn's Disease ☐ Ulcerative Colitis
  ☐ Other
☐ Ear/Eye/Nose/Throat Disorders
☐ Endocrine Disorders
☐ Fracture/Broken Bone
☐ Heart Disorders
  ☐ Angioplasty ☐ Bypass
  ☐ Heart Attack ☐ Other
☐ High Cholesterol
☐ High Blood Pressure
☐ Hodgkin's/Lymphoma/Leukemia
☐ Immune Disorders
☐ Infertility
☐ Kidney Disorders
☐ Knee Injury or Disorder
☐ Liver Disorder/Hepatitis
  ☐ Hepatitis B ☐ Hepatitis C
  ☐ Hepatitis D ☐ Other
☐ Lupus
  ☐ Discoid
  ☐ Systemic Lupus Erythematosus
☐ Mental, Nervous or Behavioral Disorder
  ☐ Inpatient Treatment ☐ Outpatient Treatment
  ☐ ADHD/ADD ☐ Anxiety
  ☐ Bipolar disorder ☐ Depression
  ☐ Other
☐ Migraine or Chronic Headache
☐ Multiple Sclerosis (MS)
☐ Muscle Disorders
☐ Nervous System Disorders
☐ Paralysis
☐ Partial or Total Disability
☐ Physical Disorder or Deformity
☐ Reproductive Disorders
☐ Respiratory/Lung Disorders
  ☐ Asthma ☐ Chronic Bronchitis
  ☐ COPD ☐ Other
☐ Seizures
☐ Sexually Transmitted Disease
☐ Stroke or Transient Ischemic Attack
☐ Thyroid Disorder
  ☐ Hyperthyroidism ☐ Hypothyroidism
  ☐ Growth Disorder ☐ Other
☐ Transplant
  ☐ Solid Organ ☐ Blood or Marrow
☐ Urinary Disorders
☐ Vascular Disorders

2. In the last 5 years, have you or any of your dependents included on this enrollment form:
   a. 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

3. Are you or any of your dependents included on this enrollment form currently pregnant? .....☐ Yes ☐ No
   a. If yes, 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

4. Have medications been prescribed in the past 18 months for you and/or any dependents included on this enrollment form. (Include pills, creams, injections, liquids, inhalers, pumps, etc.) .....☐ Yes ☐ No

G – DETAILS

Please provide FULL DETAILS to any yes/checked answers in section F; including the name of the Applicant(s), condition(s), treatment(s), medication(s), and dates. If more space is needed please attach a separate page with details; include the Employee's name.

Question	Person	Condition/Diagnosis	Dates Treated	Treatment including Medications and Dosage	Date Last Taken	Prognosis

H – *** 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.

I – APPLICATION Authorization, Signature, and Health Plan Arbitration Agreement:

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 National General Benefits Solutions to determine eligibility for coverage under the 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 National General Benefits Solutions.

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 National General Benefits Solutions, its legal representative or any medical records retrieval service National General Benefits Solutions 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 National General Benefits Solutions, 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 National General Benefits Solutions 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 National General Benefits Solutions to make eligibility or enrollment determinations relating to me and/or my dependents or for National General Benefits Solutions underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, National General Benefits Solutions may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying National General Benefits Solutions in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, National General Insurance Company, 2200 Highway 121, 2nd Floor, Bedford, TX 76021. Such revocation will not be valid if National General Benefits Solutions has taken action in reliance on the authorization.
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 acknowledge that I have been advised that (1) fraudulent statements or misrepresentation of material facts may result in retroactive termination of your coverage and (2) knowing and willful misstatements in this individual health questionnaire may represent a criminal violation of 18 US Code Section 1347 (punishable by up to 10 years in prison).

Employee/Primary Applicant Signature:_____ Date: _____