LEVEL FUNDED HEALTH PLAN
EMPLOYEE ENROLLMENT FORM

EMPLOYER | PLAN SELECTED | GROUP NUMBER

SECTION 1 **EMPLOYEE INFORMATION**

Administrative Use Only

CASE #
EMPLOYEE #
CLASS
EFFECTIVE DATE

OCC	YES	NO	
UWF 48	YES	NO	DATE
UWF 40	YES	NO	
HEALTH	YES	NO	

FIRST NAME | **M.I.** | **LAST NAME**

MARITAL STATUS SINGLE MARRIED SEPARATED DIVORCED OR WIDOWED

STREET ADDRESS

CITY | STATE | ZIP

EMAIL ADDRESS

PHONE NUMBER | SSN

GENDER | **DOB** (MM/DD/YY) | **HEIGHT** (FT'IN") | **WEIGHT** (LBS)

FULL TIME START DATE | AVG. WEEKLY HOURS | OCCUPATION

I AM ENROLLING FOR (CHECK ONE)**:** SELF ONLY SELF & SPOUSE SELF & CHILD(REN) SELF, SPOUSE & CHILD(REN)

ARE YOU AN OWNER, PARTNER OR CORPORATE OFFICER? YES NO

EMPLOYEE WAIVER YES NO

If ***YES***, I AM **NOT** ENROLLING BECAUSE: COVERED BY ANOTHER PLAN OTHER (EXPLAIN):

DEPENDENT WAIVER YES NO *If* ***YES***, I AM **NOT** ENROLLING MY: SPOUSE CHILD(REN)

I AM **NOT** ENROLLING THE ABOVE BECAUSE: COVERED BY ANOTHER PLAN OTHER (EXPLAIN):

I understand that I have the right to enroll my dependents at this time. I am voluntarily declining to enroll my dependents and have not been induced or pressured by anyone to decline such coverage. I understand that, if I do not enroll my dependents at this time and they do not have other qualifying coverage, their right to enroll in the future may be restricted.

NAME | **DATE** MM/DD/AA | **SIGNATURE**

PARTICIPANT INFORMATION
Complete for each person to be enrolled.

	PARTICIPANT NAME	RELATIONSHIP	GENDER	HEIGHT	WEIGHT	DATE OF BIRTH	SOCIAL SECURITY NO.	TOBACCO USE
1		SELF						YES NO
2								YES NO
3								YES NO
4								YES NO

Use a separate sheet if additional space is needed, and sign and attach additional pages.

SELF-FUNDED HEALTH PLAN
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SECTION 2 **PRIOR COVERAGE CREDIT**

HAVE YOU OR YOUR DEPENDENTS BEEN COVERED UNDER ANY HEALTH PLAN WITHIN THE LAST 90 DAYS? YES NO

*If **YES**, provide the following information on all coverage in force in the past 12 months. Most of this information can be obtained from your current benefit plan identification card.*

COVERAGE TYPE COMPREHENSIVE MAJOR MEDICAL OTHER (PROVIDE COPY OF BENEFIT PLAN OR SCHEDULE OF BENEFITS)

NAME OF PLAN PHONE NUMBER EFFECTIVE DATE

TERMINATION DATE REASON FOR TERMINATION

PLAN TYPE EMPLOYER SPONSORED: EMPLOYER NAME POLICY/CERT. #

INDIVIDUAL: POLICY/CERT. #

COVERAGE WAS FOR: (CHECK ONE) SELF ONLY SELF & SPOUSE SELF & CHILD(REN) SELF, SPOUSE & CHILD(REN)

SECTION 3 **MEDICAL INFORMATION**

Please make sure that all questions are answered. If yes is answered for any questions, be sure that complete information is given and all medications are listed. You may want to consult your family members when completing this form. Any medical conditions or treatments you are receiving that are not disclosed on this form will not be covered under the plan.

IN THE PAST FIVE YEARS, HAVE YOU OR ANYONE ENROLLING FOR COVERAGE HAD A **DIAGNOSIS** OF OR **CONSULTATION, TREATMENT OR MEDICATION** FOR:

BRAIN OR NERVOUS SYSTEM DISORDER	YES	NO	DIABETES OR SUGAR IN URINE	YES	NO
ENDOCRINE OR ADRENAL DISORDER	YES	NO	DIGESTIVE OR GASTROINTESTINAL DISORDER	YES	NO
LIVER, PANCREAS OR KIDNEY DISORDER	YES	NO	BREAST OR REPRODUCTIVE ORGAN DISORDER	YES	NO
ABNORMAL BLOOD PRESSURE	YES	NO	AUTOIMMUNE DISORDER	YES	NO
HEART OR CIRCULATORY SYSTEM DISORDER	YES	NO	BACK OR SPINE DISORDER	YES	NO
CHEST PAIN OR STROKE	YES	NO	RHEUMATOID ARTHRITIS	YES	NO
BLOOD DISORDER	YES	NO	MULTIPLE SCLEROSIS OR CYSTIC FIBROSIS	YES	NO
LYMPHATIC VESSEL OR GLAND DISORDER	YES	NO	SKIN OR COLLAGEN DISEASE	YES	NO
CIRRHOSIS OR HEPATITIS	YES	NO	MUSCLE DISEASE	YES	NO
LEUKEMIA OR HODGKIN'S DISEASE	YES	NO	EMPHYSEMA, TUBERCULOSIS OR CHRONIC OBSTRUCTIVE PULMONARY DISEASE	YES	NO
CANCER (EXCLUDING BASAL CELL CARCINOMA)	YES	NO			

Within the last five years, has anyone enrolling for coverage been diagnosed with or treated for human immunodeficiency virus (HIV) infection; any other acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC) condition; significant weight loss; or chronic fatigue, diarrhea, night sweats or enlarged glands? YES NO

Are you or any dependents currently pregnant? YES NO

If yes: DUE DATE ANTICIPATED C-SECTION YES NO EXPECTING MULTIPLE BIRTHS YES NO

EXPERIENCING AND/OR ANTICIPATING ANY OTHER COMPLICATIONS YES NO

If you answered YES to any of the above questions, provide the following information **(continued on the next page).**

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ABA Assured Benefits Administrators

SECTION 3 **MEDICAL INFORMATION** (Continued)

Has anyone enrolling visited a doctor, had a medical consultation or surgery, or been hospitalized in the past five years? YES NO

Are you or any dependents (whether enrolling for coverage or not) anticipating surgery, or is anyone enrolling for coverage disabled, restricted or unable to perform the normal activities of daily living and self care? YES NO

Are you or any dependents enrolling for coverage currently taking medication? YES NO

For anyone enrolling for coverage, is there any existing medical condition or problem (including any undiagnosed symptoms) that has not otherwise been disclosed on this enrollment form? YES NO

*If you answered **YES** to **any** of the previous questions in* **SECTION 3, MEDICAL INFORMATION**, *provide details below. Use a separate sheet if additional space is needed, and sign and attach additional pages. If taking medication for blood pressure, include your last three blood pressure readings.*

NAME OF PERSON WITH CONDITION OR TREATMENT	CONDITION OR TREATMENT REASON	DATES OF TREATMENT	MEDICATIONS & DOSAGES	RECOVERY STATUS	LIST ANY TREATMENT, SURGERY OR ANTICIPATED SURGERY FOR THIS CONDITION

SELF-FUNDED HEALTH PLAN
EMPLOYEE ENROLLMENT FORM

SECTION 4 **EMPLOYEE STATEMENT AND SIGNATURE**

I HEREBY: Request enrollment in the self-funded Group Health Plan (Plan) 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, and all required contributions for such coverage have been received by, the Plan. A full description of the medical expense benefits under the Plan appears in the Summary Plan Description, which summarizes the official Plan Document; The agent submitting this enrollment lacks authority to change the enrollment form, approve Plan coverage, alter Plan terms, or adjust claims; 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 an 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.

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 of 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.

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 but 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 its legal representative, agent or vendor, for the purpose of processing enrollment and claims. I acknowledge and agree that this authorization shall be valid for two (2) years; that I may revoke it in writing at any time; that I may request a copy of this authorization; that enrollment, but not processing of claims, is conditioned 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 shall be as valid as the original; that any documentation or information disclosed pursuant to this authorization may be re-disclosed and may no longer be covered by federal or state privacy laws; and that I have authority to act as the personal representative of my dependent(s) (if requesting dependent coverage).

SIGNATURE

PRINT NAME DATE

Electronic copies of this enrollment form submitted via fax, email or other electronic means shall be deemed an original.