All Savers

# Employee Enrollment – Alternate Funding

Please send correspondence to P.O. Box 19032, Green Bay, WI 54307-9032 ▪ 1-800-291-2634

**(Please fill out the entire enrollment form to avoid processing delay. Please clearly print all information.)**

**Enrollee Social Security Number** ___ ___ – ___ ___ – ___ ___ ___ **Group No.** ___ – ___ ___ ___

## Enrollee Information

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Employer Name | | | | Employer Address (If more than one location) | | | |
| Last Name | | | | First Name | | | Initial |
| ❑ Single ❑ Married | Address | | City | State | ZIP | County | |
| Phone # | ___ – ___ ___ – ___ ___ | | | Gender ☐ M ☐ F | Date of Birth | Height | Weight |
| Cell Phone # | ___ – ___ ___ – ___ ___ | | | Email Address | | | |
| Date Employed Full Time | | Average Hours Worked Per Week | | Occupation Are you an independent contractor? ☐ Yes ☐ No | | | |

## Enrollee and Dependent Information (Only for those applying).

If you need to list additional dependents, please use lined paper, sign and date it, and check this box: ☐

| | Enrollee | Spouse | Child 1 | Child 2 | Child 3 |
|---|---|---|---|---|---|
| First Name | | | | | |
| Middle Initial | | | | | |
| Last Name | | | | | |
| Gender | | ☐ M ☐ F | ☐ M ☐ F | ☐ M ☐ F | ☐ M ☐ F |
| Date of Birth | | / / | / / | / / | / / |
| Height | | | | | |
| Weight | | | | | |
| Social Security Number | | – – | – – | – – | – – |
| Primary Care Physician's Name | | | | | |
| **Eligibility and Other Insurance (insurance that will be kept in addition to this coverage)** | | | | | |
| Currently Working Full Time | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Plan to Keep Other Insurance Coverage | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Other Insurance Policy Number | | | | | |
| Name of Other Insurance Company(ies) | | | | | |
| Covered by Medicare/ Medicaid | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Medicare/Medicaid Coverage Effective Date | | | | | |

## Coverage and Change Request Information

Medical: ☐ Employee ☐ Family ☐ Employee/Spouse ☐ Employee/Dependent Child(ren)

Name of Medical Plan You Have Selected: _____

Change Request: ☐ Marriage ☐ Divorce ☐ Adoption ☐ Returning to School Full Time ☐ Court Order Date of Event: _____
(you may be required to provide proof of event)

Attach a written and signed statement by the employer for a requested coverage effective date other than employee effective date. Effective date may not be guaranteed.



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## Medical History

Has anyone on this enrollment form been diagnosed, consulted with, or been examined or treated by any health care professional during the last 5 years for any illness, injury, or health condition in any of the categories listed below? If yes, please check the box that most appropriately describes the problem and explain fully below. Please note that, if you leave out or misrepresent information, we may terminate or not renew your coverage, or we may change your monthly payment retroactive to the date your policy became effective.

**All statements contained in this entire form must be true and correct and no material information can be withheld or omitted.**

| | |
|---|---|
| 1 Cancer/Tumor ☐ Yes ☐ No | ☐ Breast ☐ Colon ☐ Leukemia ☐ Lymphoma ☐ Liver ☐ Lung ☐ Melanoma ☐ Testicular ☐ Brain ☐ Ovarian<br>☐ Cervical ☐ Prostate ☐ Other Cancer ☐ Non-Malignant Tumor – Location of Tumor_____ |
| 2 Heart/Circulatory ☐ Yes ☐ No | ☐ Aneurysm ☐ Bypass ☐ Angioplasty/Stent ☐ Congestive Heart Failure ☐ Heart Disease<br>☐ Elevated Cholesterol/Triglycerides ☐ High Blood Pressure ☐ Stroke ☐ Angina ☐ Hemophilia ☐ Blood Clots<br>☐ Pacemaker/ICD ☐ Blood Disorder ☐ Sickle Cell Anemia ☐ Other_____ |
| 3 Reproductive ☐ Yes ☐ No | ☐ Current Pregnancy (due date_____ if multiples #_____) ☐ Pregnancy Complications<br>☐ Fibroids ☐ Menstrual Disorders ☐ Breast Disorders ☐ Endometriosis ☐ Infertility<br>☐ Other_____ |
| 4 Intestinal/ Endocrine ☐ Yes ☐ No | ☐ Chronic Pancreatitis ☐ Colon Disorder ☐ Crohn's ☐ Ulcerative Colitis ☐ Diabetes ☐ Cirrhosis<br>☐ Hepatitis B/C ☐ Reflux ☐ Liver Disorder ☐ Ulcer ☐ Growth Hormones ☐ Gallbladder ☐ Gastric Bypass<br>☐ Other_____ |
| 5 Brain/Nervous ☐ Yes ☐ No | ☐ Alzheimer's ☐ Cerebral Palsy ☐ Migraines ☐ Multiple Sclerosis ☐ Paralysis ☐ Seizures/Epilepsy<br>☐ Parkinson's Disease ☐ Head Injury ☐ Cyst ☐ Other_____ |
| 6 Immune ☐ Yes ☐ No | ☐ Scleroderma ☐ ALS ☐ Psoriasis ☐ AIDS ☐ HIV+ ☐ Lupus ☐ Immuno Deficiency<br>☐ Other_____ |
| 7 Lung/Respiratory ☐ Yes ☐ No | ☐ Allergies ☐ Asthma ☐ Cystic Fibrosis ☐ Emphysema ☐ Sarcoidosis ☐ Lung Disorders ☐ Tuberculosis<br>☐ Sleep Apnea ☐ Chronic Bronchitis ☐ Pneumonia ☐ Other_____ |
| 8 Eyes/Ears/ Nose/Throat ☐ Yes ☐ No | ☐ Acoustic Neuroma ☐ Cataracts ☐ Cleft Lip/Palate ☐ Deviated Septum ☐ Glaucoma ☐ Retinopathy<br>☐ Chronic Ear Infections ☐ Chronic Sinusitis ☐ Other_____ |
| 9 Urinary/Kidney ☐ Yes ☐ No | ☐ Kidney Stones ☐ Kidney Disorders ☐ Bladder Disorders ☐ Polycystic Kidney Disease ☐ Prostate Disorder<br>☐ Renal Failure ☐ Other_____ |
| 10 Bones/Muscles ☐ Yes ☐ No | ☐ Rheumatoid Arthritis ☐ Osteoarthritis ☐ Bulging/Herniated Disc ☐ Joint injury<br>☐ Fibromyalgia/Chronic Fatigue Syndrome ☐ Chronic Pain Syndrome ☐ Shoulder Disorder ☐ Knee Disorder<br>☐ Spina Bifida ☐ Back Disorder ☐ Neck Disorder ☐ Other_____ |
| 11 Behavioral Health ☐ Yes ☐ No | ☐ Anxiety/Depression ☐ ADHD ☐ Bipolar Depression ☐ Manic Depression ☐ Schizophrenia ☐ Autism<br>☐ Eating Disorder ☐ Suicide Attempt ☐ Inpatient Alcohol/Drug ☐ Inpatient Mental Health Hospital<br>☐ Substance Abuse ☐ Other_____ |
| 12 Transplant ☐ Yes ☐ No | ☐ Bone Marrow ☐ Organ ☐ Discussed Possible Future Transplant ☐ Stem Cell ☐ Transplant Complications<br>☐ Other_____ |
| 13 Other ☐ Yes ☐ No | ☐ Condition not mentioned above with claims in excess of $5,000 ☐ Disability ☐ Congenital Disorder |
| 14 Tobacco ☐ Yes ☐ No | ☐ Anyone on this enrollment form used tobacco products in the past 12 months: Person _____ |
| 15 Medications ☐ Yes ☐ No | ☐ Current Medications:<br>Person _____ # of Meds ___ Person _____ # of Meds ___ (list meds below)<br>☐ Medications taken within the past 12 months:<br>Person _____ # of Meds ___ Person _____ # of Meds ___ (list meds below) |

Please give details of all "yes" answers above. (If additional space is required, please attach a separate sheet and date and sign that sheet).

| Question # | Person | Condition/Diagnosis | Treatment /Meds | Physician's Name | Dates Treated | Prognosis |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
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## Prior Medical Coverage Information

☐ Yes ☐ No Have you or any dependents applying for coverage been covered by this employer's prior group medical plan?

☐ Yes ☐ No Have you or any dependents applying for coverage been covered by any medical plan other than this employer's prior group plan?
If yes:

Insurance Company Name _____ Phone # _____ Policy/Group #_____

Termination Date _____ Effective Date_____ Reason for Termination _____

Who was covered?_____

Type of Plan: ☐ Prior Employer Group Plan ☐ Spouse's Employer Group Plan ☐ Individual Policy ☐ Other_____

## Signature

I declare all statements contained in this entire form, and in any other health insurance administration and/or coverage application form that I completed within the last 90 days that was provided to All Savers, are true and correct and that no material information has been withheld or omitted. I understand and agree that the Plan Sponsor is not bound by any statement made by or to any agent unless written herein. I agree that no medical benefits will be effective until the date specified in the Summary Plan Description. If I am now waiving medical coverage for myself and/or for my dependents, I have read the entire Waiver provision and understand the enrollment requirements if I make a request for such coverage at a later date.

Coverage is effective only after approval and satisfaction of any probationary period.

In some states, any person who, knowingly and with intent to defraud an insurance company or plan administrator, submits an enrollment form or files a claim containing any materially false information may be guilty of fraud, which is a crime.

All pages must be attached and complete, including this authorization, for the enrollment form to be considered complete. Incomplete enrollment forms may be rejected.

### Authorization to Disclose Medical Information for Enrollment

I hereby authorize those physicians, medical practitioners, hospitals, clinics, veterans administration facilities, pharmacy benefit managers, medical information services, urgent care facilities, and other medical or medically related entities, insurance or reinsurance companies, and consumer reporting agencies that have information available as to the present or former physical health condition, including drug or alcohol abuse, and/or treatment of me or my dependents proposed for coverage to release any and all such information, including, but not limited to, medical records, health care provider notes, laboratory tests and results, diagnoses, treatment, and prognoses. I understand the information obtained by use of this authorization may be used to determine eligibility for issuance of health coverage for me and my dependents. This authorization is not applicable to psychotherapy notes.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall expire 15 months after the termination of any coverage I obtain. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. Any information obtained will not be released to any person or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my enrollment for the coverage, for any claim, for medical management purposes, or as may be otherwise lawfully required or as I may further authorize.

Enrollee Signature X _____

Date_____

If signed by a representative of enrollee, please indicate the representative's legal authority to act on behalf of enrollee.

_____

| Waiver (Please complete if you are waiving medical coverage.) | |
|---|---|
| I waive medical coverage for:<br>☐ Spouse ☐ Self (and dependents)<br>☐ Dependent Children | Please state reason for waiving coverage: _____<br>Qualifying Coverage: _____ Other _____ |

If I have waived coverage for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in the plan, provided that I request enrollment within 31 days after my other coverage ends because of involuntary loss of other coverage (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll my dependents, provided that I request enrollment within 31 days after the date of the event.

Applicant Signature X _____ Date _____

## YOUR RIGHTS REGARDING THE RELEASE AND USE OF GENETIC INFORMATION

The results of any genetic test, including genetic test information, shall not be used as the basis to (1) terminate, restrict, limit or otherwise apply conditions to the coverage of an individual or family member under the plan, or restrict the sale of the plan to an individual or family member; (2) cancel or refuse to renew the coverage of an individual or family member under the plan; (3) deny coverage or exclude an individual or family member from coverage under the plan; (4) impose a rider that excludes coverage for certain benefits or services under the plan; (5) establish differentials in monthly costs or cost-sharing for coverage under the plan; (6) otherwise discriminate against an individual or family member in the provision of insurance.

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# Aetna AFA Medical and Stop Loss Employee Enrollment/Change Form

**Conditions of Enrollment**

I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until Aetna approves both this enrollment form and the employer application. I agree that my employer or its agent may send this enrollment form to Aetna. I authorize all my doctors, pharmacies, hospitals and other health care providers ("Providers") to give Aetna any and all personal health information about me and others listed on this form. This authorization covers all health matters including those involving mental health, substance abuse and HIV/AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.

I certify that all information and statements on this enrollment form are true and complete to the best of my knowledge and that I have authority to make statements on behalf of any dependents listed on this form. I am employed by the employer on page 1 and working full-time for this employer.

**I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.**

| Employee Signature | Date |
|---|---|
| | |

There are no medical changes from the All Savers individual medical questionnaire.

**F. Decline/Waive** – *To be completed if medical coverage is declined or refused by an eligible employee and/or their eligible family members.*

| **Medical Coverage Declined for:** | **Reason for declining coverage** | | | |
|---|---|---|---|---|
| ☐ Myself | ☐ Parental coverage | ☐ TRICARE | ☐ VA coverage | ☐ Insurance through another job |
| ☐ Spouse/Civil Union/Domestic Partner | ☐ COBRA coverage | ☐ Medicare | ☐ Spousal/Civil Union/Domestic Partner group coverage | ☐ Individual coverage – On or Off Exchange |
| ☐ Children | ☐ Retiree coverage | ☐ Medicaid | ☐ Another group plan provided by my employer | ☐ Do not want |
| | | | | ☐ Other _____ |

| | |
|---|---|
| I acknowledge I have been given the right to apply for this coverage, however, I am electing not to enroll. By declining this group coverage I acknowledge that I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage. I and/or my dependents have made this decision of my/their own accord, with no pressure from my employer, my employer's agent or the insurance carrier. | ***Please sign here ONLY if you are declining coverage for yourself and/or dependent(s).*** <br> **X Employee Signature** _____ <br> ***Date (Month/Day/Year)*** _____ |

National General
Benefits Solutions

# Employee Acknowledgement and Authorization Regarding Enrollment

By signing this form, I authorize the use and disclosure of Protected Health Information (PHI) to National General Benefits Solutions ("NGBS") for the purposes of determining eligibility for enrollment or benefits under a group health plan and risk-rating by for stop-loss insurance coverage issued by Time Insurance Company, National Health Insurance Company, Integon Indemnity Corporation, or Integon National Insurance Company to my employer.

I understand and acknowledge that I have elected to participate in the Section 125 plan offered by my employer, and I agree that my qualified insurance premiums may be paid by my employer through pre-tax salary/earnings reductions. I further acknowledge that my Social Security contribution and subsequent Social Security benefit will be slightly reduced.

I understand that my answers in a previous Employee Application, Employee Enrollment Form or other similar form will be relied upon to underwrite my employer's stop-loss insurance coverage and to set the contributions of my employer's self-funded plan. I understand that if I so choose, I may complete an NGBS Employee Eligibility Statement in lieu of signing this Amendment.

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 enrollment 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.

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, insurance or reinsurance company or employer, having information about me or my minor children to provide all such information as may be requested to NGBS, its legal representative or any medical records retrieval service NGBS may engage.

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 NGBS. 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 NGBS pursuant to this authorization will be protected by federal and state privacy laws and regulations.

I understand and agree that in connection with my application for coverage under the Program: (1) NGBS may obtain consumer reports which may include credit information, a driver history report, and/or personal or privileged information from third parties; (2) such information may be disclosed to affiliated or unaffiliated third parties without my prior permission but only as permitted or required by law; (3) upon my written request, NGBS will inform me if a consumer report was requested and the name and address of the consumer reporting agency that furnished the report; (4) I may also request access to and correction of information NGBS has collected on me; (5) NGBS may request and use subsequent consumer reports in updating and renewing any insurance afforded in connection with this Application; and (6) NGBS will furnish a more detailed explanation of its information practices

upon my request.

In connection with this application for insurance, NGBS will review my credit report or obtain or use an insurance credit score based on the information contained in that credit report. NGBS may use a third party in connection with the development of my insurance credit score. I may request that my credit information be updated and if I question the accuracy of the credit information, NGBS will, upon my request, reevaluate me based on corrected credit information from a consumer reporting agency.

I hereby authorize NGBS to obtain consumer reports on me.

I understand that this authorization is required in order to enable NGBS to make eligibility or enrollment determinations relating to me, my spouse and/or my dependents or for NGBS to make underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, or refuse to authorize NGBS to obtain a consumer report on me, NGBS may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying NGBS in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, National Health Insurance Company, 4455 LBJ Freeway, Ste 375, Dallas, TX 75244. Such revocation will not be valid to the extent NGBS has taken action in reliance on the authorization prior to its revocation. This authorization expires upon the earliest of the following: denial of my application, declination of enrollment, or 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.

I acknowledge that knowing and willful misstatements in this enrollment form may constitute health care fraud, a criminal violation of 18 US Code Section 1347 (punishable by up to 10 years in prison).

Employee Signature:_____Date: _____

******************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.