Employee Enrollment Form

EMPLOYER / PLAN SPONSOR				DATE OF HIRE	SALARY	HOURS WORKED PER WEEK
EMPLOYEE'S NAME (LAST)	FIRST	INITIAL	MARITAL STATUS		EMPLOYEE'S OCCUPATION	
EMPLOYEE'S MAILING ADDRESS						
CITY		STATE		ZIP	ARE YOU AND YOUR DEPENDENTS U.S. CITIZENS? ☐ YES ☐NO	
EMPLOYEE'S EMAIL ADDRESS					IS YOUR SPOUSE EMPLOYED? ☐ YES ☐NO	

WAIVER OF PARTICIPATION

Each eligible employee who chooses not to apply for coverage for self, spouse, or dependent children must complete this section. I voluntarily waive Medical Coverage:

For (check all that apply): ☐ Myself ☐ My eligible spouse ☐My eligible spouse and dependent children ☐ My eligible dependent children

Reason for waiving coverage: ☐ Coverage under another plan ☐ Coverage under spouse's plan

Indicate type of other coverage: ☐ Individual ☐ Group ☐ Medicare ☐ Other (Explain) :____

☐ Cobra Date Cobra Coverage began ____ / _____ / _____

SCHEDULE OF FAMILY MEMBERS TO BE COVERED (IF NEEDED, ATTACH ADDITIONAL SHEET, SIGNED AND DATED BY THE EMPLOYEE)

	Sex	Relationship to Employee	Date of Birth	Age	Height Ft. In.	Weight Lbs.	
1.		**Employee**					
2.		**Spouse**					
3.		**Child**					
4.		**Child**					
5.		**Child**					

OTHER HEALTH COVERAGE

	YES	NO
1. Within the last 6 months, has any person to be covered: a) had any hospital, medical or major medical insurance?	☐	☐
b) applied for such insurance?	☐	☐
2. Will the coverage being applied for replace existing insurance?	☐	☐

3. Have you or any dependent enrolling been without medical coverage more than 63 days?_____. If so, date of termination.________

	YES	NO
4. Within the last 5 years, has any person to be covered been declined for life or medical insurance?	☐	☐

(If question Q4 above is answered "YES," **provide details at the bottom of the page.**

HEALTH HISTORY QUESTIONNAIRE

All of the following questions must be answered for each person applying for coverage. Use a separate sheet, if necessary. **If any "YES" answers are present, the bottom section must be completed in full before the enrollment form can be reviewed.**

INTENTIONALLY OR UNINTENTIONALLY OMITTING ANY MEDICAL INFORMATION ON ANY PERSON SEEKING COVERAGE, MAY RESULT IN CLAIM DENIAL.

Question	YES	NO
1. **In the last five years has anyone:**		
a) Suspected an illness been to or consulted a doctor, psychiatrist, therapist, medical practitioner or health care provider for any symptoms or disorders?	☐	☐
b) Had any surgery, hospitalization, observation room stay, or hospital emergency room treatment or minor emergency room clinic, urgent care clinic or outpatient treatment?	☐	☐
c) Had or been diagnosed with a physical or mental birth defect, developmental, behavioral or physical impairment condition, disorder or symptom?	☐	☐
d) Had a work related illness or injury?	☐	☐
e) Been diagnosed, treated for, consulted by a doctor or suspected of having any of the following?		
i) Aids, HIV, aids related complex (ARC), disorder of the blood, Hemophilia, immune or lymph system	☐	☐
ii) Cancer, tumors or polyp (benign or malignant), **If yes complete #5 on page 3**	☐	☐
iii) Alcoholism, mental, emotional or nervous disorders (i.e. depression)	☐	☐
iv) Diabetes, **If yes complete #2 on page 3**	☐	☐
v) Chest pain/pressure or heart condition , **If yes complete #1 on page 3**	☐	☐
vi) Liver or gallbladder problems, hepatitis or cirrhosis, **If yes complete #7 on page 4**	☐	☐
vii) High blood pressure, stroke, or other circulatory problems **, If yes complete #3 on page 3**	☐	☐
viii) Kidney, urinary, tract or prostate problems, **If yes and on dialysis complete #9 on page 4**	☐	☐
ix) Digestive problems, ulcers, hernia or colitis	☐	☐
x) Reproductive, menstrual, breast disorder or infertility treatments	☐	☐
xi) Respiratory or lung problems, bronchitis, asthma, emphysema, COPD or pneumonia	☐	☐
xii) Neurological conditions, MS, epilepsy, paralysis or seizures**, If yes complete #6 on page 3**	☐	☐
xiii) Skeletal or muscular condition, back, knee or neck pain, **If yes complete #8 on page 4**	☐	☐
xiv) Crohn's, diverticulitis, colitis, regional enteritis or ileitis , **If yes complete #4 on page 3**	☐	☐
xv) Disorders of the nervous or sense organs	☐	☐
f) Been disabled or had a treatment, diagnosis, or disorder not listed above?	☐	☐
2. Have you or any dependent, within the last 12 months, incurred more than $5,000 in medical expenses?	☐	☐
3. Are you or any of your dependents covered under or eligible for Medicare Part A or Part B? If yes for what reason ______Age ______ Disability ______ End Stage Renal Disease	☐	☐
4. **a)** Are you, or is any family member currently pregnant or an expectant parent? (including adoption)	☐	☐
b) Provide due date or expectant placement date: ______________________________________		
c) Is this a High Risk Pregnancy? Yes ☐ No ☐		
d) Are there any current complications? Yes ☐ No ☐		
e) Is this a multiple birth? Yes ☐ No ☐		
5. Are you or any dependent using tobacco products or nicotine products?	☐	☐
6. **a)** Is anyone currently taking any prescribed medicines, drugs, pills, or shots? (include daily as well as medication only taken when needed)? If yes, please list below all medications and the conditions each is intended to treat.	☐	☐
b) Has anyone been prescribed a medication that they are not taking?	☐	☐
7. **a)** Has anyone been told of a need or possible need for, or is anyone planning or scheduled for future treatment, medical testing or examination (i.e. physical therapy, specialist consultation, surgery, hospitalization, medical treatment)?	☐	☐
b) Are there any symptoms present for which anyone will be seeking treatment?	☐	☐

Quest. #	Person's Name	Nature of Medical Advice or Treatment, Diagnosis, Medications, Date of Treatment, Duration of condition	Degree of recovery, Results of Treatment, Prognosis	Name, phone number and addresses of Physicians & Hospitals

1. **Heart Conditions, Chest Pain/Pressure** ______________________________________
Applicant or Dependent

   a. Check all that apply: ☐ Heart Attack ☐ Myocardial Infarction ☐ Angina ☐ Coronary Bypass ☐ Coronary Angioplasty ☐ Irregular Heart Beat ☐ Arrhythmias ☐ Atrial Fibrillation or Flutter ☐ PVCs (premature ventricular contracts) ☐ Heart Murmur ☐ Mitral Valve Prolapse ☐ Heart Valve Replacement / Surgery ☐ Transplant ☐ Congenital Heart Abnormality
   b. Date of onset ____Date of recovery ____
   c. Was surgery performed? _________ List all surgeries: type and date? ____
   d. List all heart medication and dosages: ____

2. **Diabetes** ______________________________________
Applicant or Dependent

   a. Date of onset ____Current blood sugar level and date ___________________________
   b. Are you on ____oral or____ injectable medications? Name_________________ Dose _______________ Frequency Number of units of insulin _________________
   c. Do you use an insulin pump? ☐YES ☐NO
   d. Any hospitalizations required? ☐YES ☐NO. If so, indicate the dates and reason ___________________________________
   e. Any eye, kidney, circulatory problems or complications? ☐Yes ☐NO If YES, explain complication________________
   f Do you monitor your blood sugar levels? ☐Yes ☐NO If YES, how often?________________
   g. Do you have a home glucose-monitoring device? ☐Yes ☐NO
   h. How often are you examined by your physician? ____________________

3. **High Blood Pressure (Hypertension), Stroke, Circulatory Problems** ______________________________________
Applicant or Dependent

   a. Age when first diagnosed ______________________________Year when treatment began _________________________________
   b. Is medication being taken? ☐YES ☐NO. If YES, Name __________________________Dosage ____________________
   c. Any hospitalizations required? ☐YES ☐NO. If so, indicate the dates and reason ___________________________________
   ____
   d. Please indicate the dates and the results of the last three blood pressure readings taken by either you ☐ or your doctor ☐.
   Date _______________________ Reading ___________________ Date ___________________ Reading __________________
   Date _______________________ Reading ___________________
   e. Please indicate the date and results of your electrocardiogram (EKG) or stress test (if none, state "none") ___________________
   ____

4. **Crohn's Disease, Diverticulitis, Regional Enteritis or Ileitis, Colitis** ______________________________________
Applicant or Dependent

   a. Type ____ Date of last attack or episode? ___________________
   b. Date first diagnosed ____________________________ Number of attacks in the past 12 months ___________________________
   c. Surgically corrected? ☐YES ☐NO. If YES give year, procedure, and the outcome ___________________________________
   ____
   d. Is Medication being taken? ☐ YES ☐ NO. If YES, Name ____________________________ Dosage ____________________
   e. Other complications or medical impairments? Specify, details: ____

5. **Cancer, Tumor, or Polyp** ______________________________________
Applicant or Dependent

   a. Give type and location ____ ☐ Malignant? or ☐ Benign?
   b. Date diagnosed _____________________ Surgically removed? ☐YES ☐ NO. If YES, give date ________________________
   c. Did you receive radiation therapy?____________ If yes, how many treatments?____________ Date of last treatment___________
   d. Did you receive chemotherapy?______________ If yes, how many treatments?____________ Date of last treatment___________
   e. Any recurrence? ☐YES ☐NO. If YES, give date of treatment and results ____
   f. Was there any lymph node involvement? ☐YES ☐NO
   g. Any metastasis? ☐YES ☐NO
   h. Current Treatment? ____

6. **Neurological Conditions, MS, Epilepsy, Paralysis or Seizures** ______________________________________
Applicant or Dependant

   a. Type ____Date of last episode _____________________________
   b. Number of episodes per year _______________________Year in which condition diagnosed ____________________________
   c. Is medication currently being taken? ☐YES ☐NO. If YES, Name _______________________Dosage __________________
   d. Date of last hospitalization or surgery? ____
   e. Date first diagnosed ____
   f. Cause of Seizure Disorder ____

7. Liver or Gallbladder problems, Hepatitis or Cirrhosis

____
Applicant or Dependant

Date of diagnosis __________ Severity __ Mild __ Moderate __ Severe Are medications being taken? __Yes __ No If yes, please list ______________________________________ Any discussions of transplant? __ Yes __ No If yes, expected date _________ Current plan of treatment

____

8. Skeletal or Muscular Conditions

____
Applicant or Dependant

Location __ Back __ Neck __ Knee __ Other ____
Date of onset _______ Have you received physical therapy? __ Yes __ No Date ______ _________________
Have you received injections? __ Yes __ No Date _________ Resolved? __ Yes __ No
Is surgery being considered? __ Yes __ No
Date of last MRI or CT scan ________ Current plan of treatment ____________________________________

9. Dialysis

____
Applicant or Dependant

Specify Type ___________________________

Date of diagnosis _________
Frequency of dialysis treatments? _____________________