ELITE STRATEGIES

EMPLOYEE ENROLLMENT FORM

Self-Funded Medical Coverage for **Groups with 5 or More Lives**

Employer Name:_____	Employer Location (if more than one) _____

ENROLLEE INFORMATION

Last Name:	First Name:	Initial:	Gender: ☐ M ☐ F ☐ Single Height:_____ ☐ Married Weight: _____
Address:	City:	State: Select St	Zip:
County:	Home Phone #:	Enrollee Social Security Number:	
Date of Birth: Date Employed Full Time:	Occupation: Are you an independent contractor? ☐ Y ☐ N	Annual Salary: $	Average Hours Worked Per Week:

WAIVER

(Please complete if you are declining medical coverage)

Check all of the following that apply: I waive medical coverage for: ☐ Employee ☐ Spouse ☐ Child(ren)	Reason for waiving coverage:_____ 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 coverage, 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. I further understand that if I am considered a late enrollee, I may be declined from coverage or excluded from coverage for a period of time as defined in and where permitted by law, and I may be required to provide, where allowed by law, Medical History satisfactory to the Plan Sponsor or Administrator, for myself and/or my dependents..

ELIGIBILITY & OTHER INSURANCE INFORMATION

Currently, are you working full-time? ☐ Y ☐ N If no, explain: _____ _____	Do you or any family members intend to keep other insurance coverage in addition to this coverage? ☐ Y ☐ N If yes, list family members: _____
List the name of the other insurance company(ies) and the policy number(s):_____	List family members covered by Medicare and their effective date:_____

COVERAGE & CHANGE REQUEST INFORMATION

Coverage Level: ☐ Employee ☐ Family ☐ Employee/Spouse ☐ Employee/Child(ren)	Name of medical plan you have selected:_____ PPO Network Name:

Change Request: ☐ Marriage ☐ Divorce ☐ Adoption ☐ Returning to school full-time ☐ Court Order ☐ Loss of Coverage

Date of Event (you may be required to provide proof of the event):

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

FAMILY INFORMATION

(Only for those applying for coverage)

First Name & M. I. (last name if different)	Gender	Date of Birth	Height	Weight	Social Security No.	Primary Care Physician's Name
Spouse:	☐ M ☐ F					
Child:	☐ M ☐ F					
Child:	☐ M ☐ F					
Child:	☐ M ☐ F					

REQUIRED MEDICAL INFORMATION

1. ☐ Y ☐ N Are you or any dependent disabled, hospital confined, or pregnant? If pregnant, due date: ____/____/____
   If pregnant, are you expecting a multiple birth / having complications / planning a C-Section? ☐ Y ☐ N
2. ☐ Y ☐ N Have you or any eligible dependent used tobacco products in the past twelve (12) months?
3. ☐ Y ☐ N Are you or any eligible dependent receiving treatment; taking medication; receiving follow up care; scheduled for or awaiting results of any tests, biopsies, procedures or lab work; been advised to have a test; or been advised of a condition that will require attention in the next twenty-four (24) months?
4. ☐ Y ☐ N Have you or any eligible dependent ever been declined, postponed, ridered, or rated up for medical, disability, or life insurance with another insurance carrier? If yes, please explain.
5. ☐ Y ☐ N In the past five (5) years, have you or any eligible dependent to be insured had any symptoms, diagnosis, consultation, testing, treatment, follow up care, or taken any medication or received counseling for:

a. ☐ Yes ☐ No Diabetes
b. ☐ Yes ☐ No Kidney Disorder
c. ☐ Yes ☐ No Infertility
d. ☐ Yes ☐ No Neurological Disorder
e. ☐ Yes ☐ No Arthritis/Back/Joint Disorder
f. ☐ Yes ☐ No Cancer/Tumor
g. ☐ Yes ☐ No Liver Disorder/Hepatitis
h. ☐ Yes ☐ No Systemic Lupus/Multiple Sclerosis
i. ☐ Yes ☐ No Mental Disorder Alcohol/Drug Abuse
j. ☐ Yes ☐ No Heart/Blood/Vascular/Hypertension
k. ☐ Yes ☐ No Birth Defects/Congenital Disorder
l. ☐ Yes ☐ No Stroke
m. ☐ Yes ☐ No Organ/Tissue Transplants
n. ☐ Yes ☐ No Respiratory/Lung Disorder
o. ☐ Yes ☐ No Immune System Disorder
p. ☐ Yes ☐ No Acquired Immune Deficiency Syndrome(AIDS)/AIDS Related Complex (ARC)/HIV

Please provide details to "Yes" answers, including information regarding last doctor visit and/or physical examination and all medications taken (attach extra pages if needed with signature and date.)

Question/Letter	Name	Illness/Impairment	Dates Treated	Medication Name, Dosage and Frequency/Treatment/ Surgery/Treating Physician

EMPLOYEE AGREEMENT – SIGNATURE REQUIRED
***To be a valid enrollment, your signature and the date you sign it are required.**

I understand that the previous answers will be relied upon by the Plan Sponsor in the issuance of a Summary Plan Description. I declare all statements contained in this entire form about me and my dependents are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand that my intentional misrepresentation of a material fact or my failure to report information about me or my dependents may be used as the basis to rescind, terminate or modify coverage for me or my dependents. Rescind means that the coverage was never in effect. 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 coverage will be effective until the date specified by the Plan Sponsor in the Summary Plan Description. The actual effective date may not be the requested effective date. If I am now waiving medical benefits for myself and/or my dependents, I have read the entire Waiver provision, and understand the enrollment requirements if I make request for such benefits at a later date. I authorize my employer to deduct the necessary contribution toward the benefits. I reserve the right to revoke this deduction authorization at any time upon my written notice. Benefits are effective only after approval by the Plan Sponsor or Administrator and satisfaction of any probationary period. To assist with determining my creditable coverage, I authorize any insurance company, third party administrator, or other carrier or provider of health benefits to release to the third party administrator and/or Plan Sponsor certificates of creditable coverage and all such information. Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false information may be found guilty of fraud, which is a crime, in a court of law and may be subject to fines and confinement in prison. This will not be considered as a complete application unless all pages are attached and completed.

☐ I understand that information on this application is valid for a maximum of 60 days from the date of signature.

Enrollee Signature X _____ Date (required) _____

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

SIGNATURE REQUIRED / AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR ENROLLMENT

I also hereby authorize any physician, medical practitioner, hospital, clinic, Veterans administrations facility, other medical or medically related facility, insurance or reinsurance company, pharmacy, pharmacy benefit manager, health plan, or Consumer Reporting Agency, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and/or treatment of me or my minor children and other non-medical information of me and my minor children, to release to the third party administrator, any other excess loss insurance carrier designated by the Plan, or its legal representative, any and all such information as required for determination of eligibility for benefits. I also understand that my dependents of legal age, in order to be eligible for benefits, may be required to sign a similar release of medical records for the purpose of determining the accuracy of statements made by me on this application and for the ultimate determination of eligibility for benefits under the Plan. I understand that I may request a copy of this authorization at any time. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I agree that a photographic copy of this authorization shall be as valid as the original, and that this authorization shall be valid for 2 ½ years from the date shown below. I understand the information obtained by use of this authorization may be used by the Plan Sponsor, third party administrator, and any excess loss insurance carrier designated by the Plan to determine eligibility for health coverage, and eligibility for benefits under an existing plan, for myself and my dependents. 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. I also understand that I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

Enrollee Signature X _____ Date (required) _____

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