A Turn For The Better

EMPLOYEE SELF-FUNDED HEALTH PLAN ENROLLMENT CARD

May be Photocopied or Duplicated for use. Please complete in ink and initial any alterations

FULL NAME OF EMPLOYEE			MARITAL STATUS	**ADM. USE ONLY**
RESIDENCE ADDRESS	CITY	STATE	ZIP	CASE NO.
TELEPHONE NUMBER (include area code)	Best time to contact (if additional information is required by administrator)			EMPLOYEE NO.
DATE BEGAN FULL TIME (mm/dd/yy)	SOCIAL SECURITY NUMBER			CLASS
EMPLOYED BY	EMPLOYER'S PHONE (include area code)	AVG. NO. HOURS WORKED WEEKLY		EFFECTIVE DATE
EMPLOYER'S LOCATION – STREET ADDRESS	CITY	STATE	ZIP	OCC YES ❑ NO ❑
OCCUPATION AND DUTIES				UWF 48 YES ❑ NO ❑ DATE _____
☐ I AM ☐ I AM NOT AN OWNER, PARTNER OR CORPORATE OFFICER				UWF 40 YES ❑ NO ❑
I Am Enrolling for (check one): ☐ SELF ONLY ☐ SELF AND SPOUSE ☐ SELF AND CHILD(REN) ☐ SELF, SPOUSE & CHILD(REN)				HEALTH YES ❑ NO ❑

SECTION 1 – EMPLOYEE INFORMATION

EMPLOYEE / DEPENDENT WAIVER

In you are waiving coverage or if you have dependents (spouse and/or children) and are not enrolling **all** of them, please complete the following:

I AM NOT ENROLLING MY (check all that apply): ☐ **SELF** ☐ **SPOUSE** ☑ **CHILD(REN)**
BECAUSE: ☐ Covered by another group/individual health plan. ☐ Other (explain) _____

I understand 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, with a delayed effective date or an extended Pre-Existing Condition Limitation Period.

PARTICIPANT INFORMATION **Complete for each person to be enrolled (use additional sheet if necessary).**

NAMES OF PARTICIPANTS	RELATIONSHIP	SEX	HEIGHT	WEIGHT	DATE OF BIRTH	SOCIAL SECURITY NUMBER	**ADM. USE ONLY** MUW	MHX	LAT	D&R	PXT
1. Employee Name	Self										
2.											
3.											
4.											
5.											

SECTION 2 – PRIOR COVERAGE CREDIT

Have you or your dependents been covered under any health benefit plan within the last 90 days?..... ☐ YES ☐ NO

If Yes, to establish prior coverage credit, please 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 (please provide copy of the benefit plan or schedule of benefits)

Name of Health Plan_____Health Plan Phone Number (_____) _____

Effective Date of Prior Coverage _____Termination Date_____

Reason for Coverage Termination _____

Plan Type ☐ Employer Sponsored Employer Name _____Policy/Cert. Number _____

☐ Individual Policy/Certificate Number_____

Coverage was for (check all that apply): ☐ Self ☐ Spouse ☐ Children

SECTION 3 – MEDICAL INFORMATION

Please provide details for any "Yes" answer below

1. In the past 5 years, have you or anyone enrolling for coverage had a diagnosis of or consultation, treatment or medication for:

	YES	NO		YES	NO
Brain or Nervous System	☐	☐	Diabetes or Sugar in Urine	☐	☐
Endocrine or Adrenal Disorder	☐	☐	Digestive or Gastrointestinal Disorder	☐	☐
Liver, Pancreas or Kidney	☐	☐	Breast or Reproductive Organs	☐	☐
Abnormal Blood Pressure	☐	☐	Autoimmune Disorders	☐	☐
Heart or Circulatory System	☐	☐	Disorders of Back or Spine	☐	☐
Chest Pain or Stroke	☐	☐	Rheumatoid Arthritis	☐	☐
Blood Disorder	☐	☐	Emphysema, Tuberculosis, Chronic		
Lymphatic Vessels or Glands	☐	☐	Obstructive Pulmonary Disease	☐	☐
Cirrhosis or Hepatitis	☐	☐	Multiple Sclerosis or Cystic Fibrosis	☐	☐
Leukemia or Hodgkin's Disease	☐	☐	Skin or Collagen Disease	☐	☐
Cancer (excluding Basal Cell Carcinoma)	☐	☐	Disease of the Muscles	☐	☐

2. Within the last 5 years, has anyone enrolling for coverage been diagnosed as having or been treated for human immunodeficiency virus (HIV) infection, any other acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC) condition, significant weight loss, chronic fatigue, diarrhea, night sweats or enlarged glands? ☐ YES ☐ NO

3. Are you or any dependent (whether enrolling for coverage or not) currently pregnant or 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

4. During the past 5 years, has anyone enrolling for coverage visited a doctor, had a medical consultation, had surgery, or been hospitalized? ☐ YES ☐ NO

5. Are you or any dependent enrolling for coverage currently taking medication? ☐ YES ☐ NO

6. 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? If "yes" answer, provide details below. ☐ YES ☐ NO

Use this space to give details to any "YES" answer to questions 1 through 6. Use a separate sheet if additional space is needed; sign & attach additional pages. If taking medication for high blood pressure, please include your last 3 blood pressure readings.

Person	Medical Condition or Specific Reason for Treatment	Dates of Treatment	Medications & Dosages	Recovery Status	Please list any treatment, surgery or anticipated surgery for this condition.

Complete information on all pages in ink. Sign and date last page.

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.

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 the 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 of Employee X _____ Date _____

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

RETURN ENROLLMENT CARD TO MCA ADMINISTRATORS INC.

Complete information on all pages in ink. Sign and date last page.