1. Determine whether you want to enroll, decline coverage or change information and complete the corresponding box.

2. Complete the section entitled “General Information.”

3. If you have life coverage, complete the beneficiary information in the section entitled “Life Insurance.”

4. If you are electing medical or dental coverage, complete the sections entitled “For all Coverages” and “Medical Coverage.”

    - If you select the HMO, POS or Open Access plan, be sure to select a Primary Care Physician (PCP) for yourself and each covered dependent. Your PCP can provide most medical services and can assist with hospital and specialist recommendations.

    - If you select the PPO plan, do not supply provider information.

    - If you need help selecting a PCP, contact Member Services.

5. If you are electing medical or dental coverage, complete the sections entitled “Health History,” and “Family Medications.”

6. Read the “Disclosure Information.”

7. Sign and date the application (needed on two pages).

8. Remove this instruction card, make a copy of the application for your records and turn in the completed application to your Plan Administrator.

We look forward to meeting your family’s health care needs.

BENEFIT PLAN ENROLLMENT/CHANGE FORM

ENROLLING

Enrollment for:

- ☐ Myself and my dependents (family coverage)
- ☐ Myself only (single coverage) because:
  - ☐ I have no dependents
  - ☐ My dependents have other insurance
  - ☐ I don't wish to purchase dependent coverage

Plan Selections:

Medical	EE	EE & SP	EE & CH	Family	Dental	EE	EE & SP	EE & CH	Family
HMO	☐	☐	☐	☐	Dental +	☐	☐	☐	☐
POS	☐	☐	☐	☐	Indemnity Dental	☐	☐	☐	☐
PPO	☐	☐	☐	☐	POS Dental	☐	☐	☐	☐
Open Access	☐	☐	☐	☐					
HDHP-HSA	☐	☐	☐	☐					

DECLINING COVERAGE

Reason:

- ☐ I have other insurance
- ☐ Other_____

_____

CHANGING INFORMATION

- ☐ Updating General Information
- ☐ Transferring To a Different Plan
- ☐ Changing PCPs
- ☐ Adding a Dependent

TO BE COMPLETED BY EMPLOYER

Company Name:

Date of Full-time Employment | Division/Location:

Original Effective Date of EE's Coverage: | Original Effective Date of Dependent(s) Coverage:

Earnings $_____

- ☐ Hourly
- ☐ Monthly
- ☐ Weekly
- ☐ Yearly
- ☐ Bi-Monthly

GENERAL INFORMATION (Always Complete This Section)

Name: Last First MI

Daytime Telephone:

Evening Telephone:

Street:

Email Address:

City: State: Zip Code:

Marital Status:
Date of Marriage: _____/_____/_____

- ☐ Separated
- ☐ Single
- ☐ Divorced
- ☐ Married
- ☐ Widowed

County:

Occupation:

LIFE INSURANCE

If your employer is paying the full cost for this coverage, you are automatically covered under this benefit.

Beneficiary	Relationship	%
1.		
2.		
3.		

FOR CARRIER USE ONLY

Plan Number: | Effective Date:

Division: | Late App: | Class/Benefit Group:

Is Employee/Dependent on COBRA continuation: ☐ YES ☐ NO If YES, attach copy of original COBRA enrollment form.

FOR ALL COVERAGES / MEDICAL COVERAGE

Name (Last, First, MI)	Date of Birth	Sex	Full-time Student	Primary Care Physician (Last, First, MI) Please list name(s) exactly as they appear in the directory.		Existing Patient
Self:		☐ M ☐ F		PCP:	Medical Group:	☐ YES ☐ NO
Social Security Number:				Address:		
Spouse:		☐ M ☐ F		PCP:	Medical Group:	☐ YES ☐ NO
Social Security Number:				Address:		
Child:		☐ M ☐ F	☐ YES ☐ NO	PCP:	Medical Group:	☐ YES ☐ NO
Social Security Number:				Address:		
Child:		☐ M ☐ F	☐ YES ☐ NO	PCP:	Medical Group:	☐ YES ☐ NO
Social Security Number:				Address:		
Child:		☐ M ☐ F	☐ YES ☐ NO	PCP:	Medical Group:	☐ YES ☐ NO
Social Security Number:				Address:		

By my signature below, I acknowledge that I have read and understand the disclosure in this application. I authorize the required payroll deduction for contributory benefits. I also represent that all information shown on this application is correct.

Employee Signature: | Date: (MM/DD/YYYY)

Form Number

	FULL NAME	GENDER	DOB	HEIGHT	WEIGHT	TOBACCO (use during past 5 yrs)
Employee/Self		☐ F ☐ M	/ /	_____Ft _____In	_____ Lbs	☐ YES – when was last use? ☐ NO
Spouse/Domestic Partner		☐ F ☐ M	/ /	_____Ft _____In	_____ Lbs	☐ YES – when was last use? ☐ NO
Child/Dependent		☐ F ☐ M	/ /	_____Ft _____In	_____ Lbs	☐ YES – when was last use? ☐ NO
Child/Dependent		☐ F ☐ M	/ /	_____Ft _____In	_____ Lbs	☐ YES – when was last use? ☐ NO

HEALTH HISTORY: Please check YES or NO to each category. For any YES response, provide the details in the section below for any condition(s) that were diagnosed, consulted on or treated during the past 5 years.

During the past 5 years, have you or your dependent(s) been diagnosed with, consulted on, treated or hospitalized for any adverse health conditions (see list of potential conditions below)? ☐ YES ☐ NO If YES, please complete the detail below.

☐ YES ☐ NO 1. Heart/Circulatory (including but not limited to Angioplasty/Stent, Aneurysm, Blood Clots, Blood Disorder, Bypass, Cardiac Arrhythmia, Congestive Heart Failure, Coronary Heart Disease, Heart Murmur, Hemophilia, High Blood Pressure, Peripheral Artery Disease, Pacemaker/Defibrillator, Sickle Cell Anemia, Stroke/TIA or Ventricular Tachycardia)
If YES to Stroke/TIA, please include additional information in the "Comments" section below including residuals (complications) and the degree of recovery.

☐ YES ☐ NO 2. Eyes/Ears/Nose/Throat (including but not limited to Acoustic Neuroma, Cleft Lip/Palate, Deviated Septum or Retinopathy)

☐ YES ☐ NO 3. Immune (including but not limited to AIDS/HIV+, CIDP, Immuno Deficiency, Lupus, Psoriasis or Scleroderma)

☐ YES ☐ NO 4. Cancer/Tumors If YES, please include additional information in the "Comments" section below including type, stage or level of advancement, if and where it has spread beyond the original site, radiation/chemotherapy, and any surgeries completed, pending or expected.

☐ YES ☐ NO 5. Neurological (including but not limited to ASL, Myasthenia Gravis, Cerebral Palsy, Multiple Sclerosis, Paralysis/Hemiplegia/Quadriplegia or Seizures/Convulsions/Epilepsy)

☐ YES ☐ NO 6. Transplants If YES, please include additional information in the "Comments" section below including transplants completed, pending, expected or discussed, type of transplant (BMT, stem cell, specific organ) and any complications or signs of rejection.

☐ YES ☐ NO 7. Arthritis (including but not limited to Osteoarthritis or Rheumatoid Arthritis)

☐ YES ☐ NO 8. Bones/Muscles/Joints (including but not limited to Bulging/Herniated Disk, Fibromyalgia, Joint Replacement, Knee Problem or Disorder, Muscular Dystrophy, Neck/Back Pain or Disorder, Regional Pain Syndrome/Chronic Pain or Spina Bifida)
If YES to Joint Replacement, please include additional information in the "Comments" section below including the date of replacement.

☐ YES ☐ NO 9. Liver/Kidney/Urinary (including but not limited to Bladder Disorder, Prostate Disorder, Liver Disease/Disorder, Hepatitis, Cirrhosis, Kidney Disease/Disorder, Renal Failure or Dialysis)
If YES to Hepatitis, please include additional information in the "Comments" section below including the type of Hepatitis.
If YES to Renal Failure, please include additional information in the "Comments" section below including whether it is end stage or chronic.
If YES to Dialysis, please include additional information in the "Comments" section below including type (hemo or peritoneal), Medicare eligible date and expected Medicare primary date.

☐ YES ☐ NO 10. Endocrine/Metabolism (including but not limited to Diabetes, Neuropathy/Other Complications, Fabry's Disease, Gaucher's Disease, Growth Hormone Deficiency/Dwarfism or Hurler's Disease)
If YES to Diabetes, please include additional information in the "Comments" section below including whether it is controlled by diet, oral medication or insulin.

☐ YES ☐ NO 11. Reproductive (including but not limited to Endometriosis, Fibroids or Ovarian Cysts)

☐ YES ☐ NO 12. Lung/Respiratory (including but not limited to Asthma, COPD/Emphysema, Cystic Fibrosis, Lung Disorder, Sarcoidosis, Sleep Apnea or Tuberculosis)
If YES to COPD/Emphysema, please include additional information in the "Comments" section below including if you are on oxygen.

☐ YES ☐ NO 13. Intestinal (including but not limited to Crohn's Disease, Diverticulitis/Diverticulum, Gallbladder Disorder, Gastric Bypass, Pancreatitis or Ulcerative Colitis)

☐ YES ☐ NO 14. Psychological (including but not limited to Alcoholism, Bipolar, Depression, Substance Abuse, Eating Disorder or Schizophrenia)

☐ YES ☐ NO 15. Current Pregnancy If YES, please include additional information in the "Comments" section below including due date, if multiple births are expected, the number of babies, complications or whether a C-Section is expected.

☐ YES ☐ NO 16. Any Other Condition Not Listed Above If YES, please include additional information below.

If more space is needed for your responses, please attach the additional information on a separate page and sign and date the page.

Name of Member with Condition	Condition/Specific Diagnosis	Diagnosis/Treatment (Including surgeries completed or expected and complications)	Diagnosis Date	Treatment Status and Date Last Treated	Comments

FAMILY MEDICATIONS: Including all oral, topical, optical, nasal, injected or IV infused therapies

Are you or your dependent(s) taking any prescription medication (including any oral, topical, optical, nasal, injected or IV infused therapies)? ☐ YES ☐ NO If YES, please provide below, information on all medication currently being taken.

Name of Member	Medicine Being Taken	Dosage & Frequency of Use	Date Prescribed	Date Last Taken or Ongoing	Condition(s) Being Taken For

I understand that I will not be individually denied coverage or be individually charged different rates as a result of my answers. However, if I knowingly provide false information on this Questionnaire, I understand and agree that it may affect the payment of claims or result in termination of my/or my dependent(s) coverage.

Employee Signature: Social Security Number: Date: (MM/DD/YYYY) Phone Number:

Form Number

DISCLOSURE INFORMATION

I hereby apply for all non-contributory coverages under my employer's plan and any contributory coverages that I have elected on the front of this application.

LIFE AND/OR DISABILITY INCOME COVERAGE

I understand that I must satisfy the eligibility and actively at work requirements at my employer's usual place of business on the date coverage for me and any eligible dependent(s) becomes effective. If I am not actively at work, I understand that coverage for me and life coverage for my eligible dependent(s) may not become effective until I return to work. I will be considered a late applicant if I decline any contributory coverage offered under this application and later apply. As a late applicant applying for coverage, I understand that proof of good health may be required for me and any eligible dependent(s).

HSA PRE-ENROLLMENT STATEMENTS

(Warning: You cannot open an HSA if, in addition to coverage under an HSA-qualified High Deductible Health Plan "HDHP", you are also covered under a Health FSA or an HRA or any other health coverage that is not an HDHP).

By checking the HDHP-HSA box in this Medical Enrollment Form, I express my intent to open a Health Savings Account (HSA) with Mellon Trust of New England, N.A., an HSA service provider arranged by Great-West Healthcare "Great-West" or any other successor HSA service provider arranged by Great-West hereafter "the HSA Service Provider." The HSA Service Provider will contact me and provide me with an HSA enrollment form, a signature card, a request for information for Customer Identification Program compliance and other related materials necessary to activate an HSA account with the HSA Service Provider.

However, if my employer has ***not*** selected Mellon Trust of New England, N.A., as the service provider, I express my intent to open the HSA with an HSA custodian/trustee that is either arranged by my employer or that I personally select. I agree to complete necessary forms and meet the requirements set forth by the HSA custodian/trustee to enable my HSA to become operational.

I understand that, with respect to my HSA opened pursuant to this arrangement, the HSA trustee/custodian will be solely responsible for all HSA service, transactions and activities related thereto. Neither my employer nor Great-West is responsible for any aspects of the HSA services, administration and operation.

I certify that I have enrolled or plan to enroll under an HDHP and am not covered under any other health coverage that is not an HDHP.

HEALTH COVERAGE

I understand that I must submit a Certificate or evidence of prior creditable coverage to receive credit toward the satisfaction of any pre-existing condition limitation specified in my employer's plan; and to be eligible for credit, the gap between the two coverages must be 63 days or less.

I and/or my eligible dependent(s) will be considered a "Special Applicant" if:

- I did not previously elect to cover myself and/or my eligible dependent(s) under my employer's policy/plan because of other health coverage and I later apply because the other coverage terminated involuntarily; or
- I did not previously elect to cover myself and/or my eligible dependent(s) and I later apply for coverage because of a change in my family status resulting from marriage, birth or adoption of a child.

I understand that to qualify as a "Special Applicant," I must apply for health coverage for myself and/or my eligible dependent(s) within 31 days after:

- Coverage under the prior health plan ends; or I marry; or I acquire a new child through birth, adoption or placement of a child for adoption.

I will be considered a late applicant if:

- I fail to qualify as a "Special Applicant" because I did not apply within the 31 days as specified above; or
- I did not previously elect to cover myself and/or my eligible dependent(s) and I later apply.

As a late applicant applying for health coverage, I realize that I may only be allowed entrance to the plan during the open enrollment period. As a late applicant, I realize that my entry to the plan may be subject to special enrollment requirements and that I must contact my Plan Administrator for details.

FOR ALL COVERAGES

I hereby authorize any insurance company, health care provider or other entity or person having knowledge of anyone listed on this application to give this new carrier or their designated agent(s) any and all records pertaining to such person's medical history for purposes of review, investigation or evaluation. For application purposes, this authorization is valid for 30 months from the date I sign it. For purposes of claims, reimbursement and receipt of services rendered, this authorization is valid during the term of such person's coverage for evaluation of the nature and medical necessity of the services received. I am, or my authorized representative is, entitled to a copy of this signed authorization.

Alaska Residents – Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona Residents – For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas Residents – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California Residents – I understand that any differences between myself (and/or my dependents) and Great-West Healthcare, including any claim of medical malpractice, will be resolved through Great-West Healthcare's grievance process, up to an including binding arbitration. Under this coverage, both the member and Great-West Healthcare are giving up the right to have differences decided by jury trial or by a court, except as state law provides for judicial review of arbitration proceedings. For your protection, California law requires the following to appear on this form. Any person, who knowingly presents a false or fraudulent claim for the payment of a loss, is guilty of a crime and may be subject to fines and confinement in state prison. Any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Colorado Residents – It unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial or insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware Residents – Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing false, incomplete or misleading information is guilty of a felony.

District of Columbia Residents – WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents – (1) I have received educational material regarding Advance Directives from Great-West Healthcare of Florida, Inc., as required by state regulations. I understand that if I wish to have Advance Directives, I need to contact my primary care physician and supply him/her with a copy of my wishes. I can receive more education about Advance Directives by contacting my primary care physician. (2) Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or any application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Georgia Residents – I understand it is my responsibility to review the number, mix and distribution of participating providers available on line at www.mygreatwest.com or by calling Member Services at 1-800-663-8081. Physicians are reimbursed on a fee for service basis.

Idaho Residents – Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete or misleading information is guilty of a felony.

Indiana Residents – A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

Kentucky Residents – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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.

Louisiana Residents – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine Residents – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota Residents – A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire Residents – Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment of insurance fraud, as provided in RSA 638:20.

New Jersey Residents – Different providers in our network have agreed to be paid in different ways by us. Your provider may be paid each time she or he treats you (fee for service). These payment methods may include financial incentive agreements to pay some providers more (bonuses) based on many factors; member satisfaction, quality of care and control of costs and use of services among them. If you desire additional information about how our primary care physicians or any other providers in our network are compensated, please call Member Services at the telephone number shown in your enrollment kit. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico Residents – Any person, who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to civil and criminal penalties.

New York Residents – FRAUD WARNING FOR HEALTH AND AD&D ONLY: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio Residents – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Residents – WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon Residents – Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

Pennsylvania Residents – 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.

Tennessee Residents – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Texas Residents – Any person, who knowingly presents a false or fraudulent claim for the payment of a loss, is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia Residents – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington Residents – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Residents of All Other States – Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

This Disclosure Information forms a part of the Application for Membership as fully as if it were contained over the applicant's signature.