



# Employee Request for Enrollment

## Groups of 2 to 50

### Medical Plans - National

Phone: (800) 237-8543 • e-mail: info@besthealthplans.com • www.besthealthplans.com  
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New Enrollment  Add Dependents

#### EMPLOYEE INFORMATION

Last Name	First Name	M.I.	DOB	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height	Weight	SSN
Residence Street Address				City		State		Zip
Employed by (name of company)	Job Title	Weekly Hours	Date of F/T hire			Marital Status: <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Name of beneficiary for life insurance	Relationship		Do you have any eligible dependent children? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, how many?					
Will this replace other health insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes			<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Other					
Name of Carrier  (Please provide a photocopy of your ID and certificate of previous coverage)								
Policy #			Effective Date			Anticipated Termination Date		

#### DEPENDANT INFORMATION

Are you insuring your dependants? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, complete the section below and explain any differences in last name, if applicable. If no, complete section I (waiver of coverage, below)	Check if Full-Time Student	Date of Birth	Sex	Height (in.)	Weight (lbs.)
Spouse:	<input type="checkbox"/>		M/F		
Child:	<input type="checkbox"/>		M/F		
Child:	<input type="checkbox"/>		M/F		
Child:	<input type="checkbox"/>		M/F		
Child:	<input type="checkbox"/>		M/F		

Eligible dependants include spouses and unmarried dependent children. Dependent children are covered through age 20, extended through age 25 if they are full-time students. Dependent children residing in Utah are covered through age 25. Dependent children residing in Texas are covered through age 24.

#### WAIVER OF COVERAGE

Complete if you or any of your eligible dependants are declining or refusing any type of offered coverage.

**I am enrolling for Life Insurance coverage ONLY.**

**I waive Medical coverage for:**

- Myself and any dependants
- Spouse only
- Eligible dependent child(ren)
- Spouse and dependent child(ren)

**I waive Dental coverage for:**

- Myself and any dependants
- Spouse only
- Eligible dependent child(ren)
- Spouse and dependent child(ren)

Reason for waiving coverage

(you must provide a reason for waiving coverage)

- Other coverage
- Cost

- Other coverage
- Cost

Please see the attached Important Information And Notice Requirements Pursuant to The Health Insurance Portability And Accountability Act of 1996 (HIPPA). I acknowledge that by declining enrollment for myself or my dependants (including my spouse and any newborn children), I or my dependants may, under certain conditions, be considered late enrollees and subject to an 18 month pre-existing conditions exclusion (may vary by state) if I/we enroll at a later date.

Employee Signature (Required if any coverage is being waived)

Date

#### PLAN & NETWORK CHOICES

Plan Choice: <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B		PPO Network Requested:							
COBRA Electees: If you are currently continuing coverage under COBRA or a state continuation plan, what is the exact date of your qualifying event?									
For Office Use Only	ER. EFF. DT	PRE-EX	COBRA EE <input type="checkbox"/> No <input type="checkbox"/> Yes	1=Employee	DEP REF	SPOUSE EE <input type="checkbox"/> No <input type="checkbox"/> Yes	DEP 19+ FTS Y H Y		
Eff Date	ER#	COVERAGES	PREV EE DEP	WP	#EES	LATE L	Newborn N	APP A DECL D	INITIALS

# HEALTHCARE EVALUATION FOR ALL EMPLOYEES AND DEPENDANTS APPLYING FOR COVERAGE

## FIRMS OF 2-50 ELIGIBLE EMPLOYEES COMPLETE THIS SECTION

1. Has any applicant in the last five years had, been medically advised of having, been treated for, or been referred for treatment (including medications), advice or hospitalization for any of the following? CHECK APPROPRIATE BOX. PROVIDE DETAILS TO 'YES' ANSWERS BELOW.

<p>A. Any disorder/disease of the heart, lungs, liver, pancreas, colon, back, bones, muscles or joints or arthritis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B. Any disorder/disease of the digestive system, urinary tract, kidneys, reproductive system? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>C. Stroke, paralysis, leukemia, cancer, tumors, neurological or seizure disorder, or birth defect? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>D. Any mental, nervous or behavioral disorder, chemical imbalance, alcoholism or drug abuse or addiction? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>E. Diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'YES', last blood sugar reading and date? Date: _____</p> <p>F. High blood pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'YES', last 3 blood pressure readings and date _____ Dates: _____</p>
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2. "Have you had or been told you had or been tested for any immune deficiency disorder, AIDS or ARC in the last 10 years?  Yes  No

3. In the past three years has any applicant had medical expenses or claims of \$5000 or more or been hospitalized?  Yes  No

4. Is the employee or dependant pregnant (whether applying for coverage or not)?  Yes  No If yes, name \_\_\_\_\_  
Anticipated due date: \_\_\_\_\_ Any history of complications, premature birth, or C-Section?  Yes  No

5. Have you or any dependants used tobacco products in the last five years?  Yes  No

### PRESCRIPTION MEDICATION — Please list below all medications prescribed or taken by you or your dependents currently and in the past two years.

Name of Individual	Name of Medication	Reason for Medication (Diagnosis)	How Long	Results

Please provide detail for all YES answers to the health questions above. You may have your treating provider complete this section.  
Print legibly and complete all columns. Attach additional paper if necessary and be sure to sign and date it.

Name of Person Treated	Name of Condition/ Diagnosis	Duration Dates From (Mo/Yr) to (Mo/Yr)	Explain Treatment, Hospitalization, Tests and Surgery	Medications	Date Last Treated	Final Results/Degree of Recovery

### FRAUDULENT INFORMATION WARNINGS

Conformity with states that may require a fraud warning—The following general Fraud Notice is intended to comply with the laws of your state. If any part of such language is found in conflict, such language shall be construed as amended to the extent necessary in order to meet the minimum requirements of your state. Any person who, knowingly and with intent to defraud or deceive any insurance company, files an application containing any materially false, incomplete or misleading information is guilty of committing a fraudulent insurance act which is a crime and subject to criminal prosecution.

### SIGNATURE REQUIRED BELOW

I, the undersigned, certify that my date of birth, date of employment and other information on this form are correct and that I am working at the employer's place of business in full-time employment at least 30 hours per week (number of hours may vary by state) and that federal, state and social security taxes are withheld from my earnings. I authorize my employer to make deductions from my earnings necessary to provide my contribution for this coverage and understand that my employer is performing this service for my benefit and not as an agent of the insurer. I understand that coverage is not in force until the effective date shown on each certificate of coverage issued to me. I understand that my employer's application will determine the coverages in force and that coverage is not in force if application for that coverage has not been made by my employer.

I understand and agree that all disputes, disagreements or controversies arising from or relating in any way to the Group Insurance Policy, including, but not limited to, whether this Arbitration Provision is valid and enforceable and whether an issue is subject to arbitration, where otherwise unable to be resolved, shall be resolved by mandatory binding arbitration.

**Medical Authorization** (I/We) hereby authorize any physician, medical practitioner, hospital, or clinic that has records or knowledge of me or my health or my dependents or their health, to give to the Beneficial Employees Security Trusts any such information. I know that I may request to receive a copy of the Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original and that this Authorization shall be valid for two years from the date shown below. I agree that insurance does not begin until this application is approved by Best Life and Health Insurance Co., my insurance certificate is issued, and the first premium is paid.

Has any person assisted you in the completion of this form?  Yes  No If 'Yes', please print that person's name: \_\_\_\_\_

\_\_\_\_\_  
Employee Signature in black ink

\_\_\_\_\_  
Date