



SECTION A - GROUP DETAILS

Company Name Account #

SECTION B - GENERAL EMPLOYEE INFORMATION

Employee's last name, first name, middle initial Social Security Number
Street number and name Apt. No.
City State Zip code
Marital status: Single Married Divorced Gender: Male Female Date of birth (MM-DD-YYYY) Spoken language
Area code/home phone number Area code/work phone number Area code/fax number E-mail address
Date of employment (MM-DD-YYYY) Job title Office Location Hours worked per week for this employer
If you are on COBRA or State Continuation, from a former employer, please indicate: COBRA State Continuation Effective date Termination date

SECTION C - REFUSAL OF COVERAGE: Please complete only if refusing coverage.

This is to certify that I have been given the opportunity to apply for group health coverage under the mentioned account number issued by Destiny Health. I understand the coverage available and I refuse coverage. All eligible Employees and their dependents must be listed as either enrolling or declining coverage when first eligible. If you or your eligible dependents do not enroll in Destiny Health when coverage is first made available and want to enroll in the future, coverage may be postponed and/or a preexisting condition exclusion may apply for up to 18 months. (Such exclusion would not apply to maternity benefits.) For more information, contact Destiny Health.

I refuse coverage for: myself my spouse my child(ren)
Reasons for refusing coverage: individual coverage COBRA or state continuation retiring covered under spouse government coverage other:
Employee's signature Date of signature
IF YOU HAVE REFUSED COVERAGE, YOU NEED NOT COMPLETE ANY FURTHER SECTIONS OF THIS ENROLLMENT FORM.

SECTION D - COVERAGE DETAILS

Coverage is for (check all that apply) Self Spouse Child(ren) (indicate number of child(ren) to be covered)
Please select one of the following two ways that money can be withdrawn from your Personal Medical Fund™ (PMF)
PMF payments equal to expenses that accumulate to the PMF Safety Net (recommended) or,
All eligible expenses, including those that do not accumulate to the PMF Safety Net. (This may increase your out-of-pocket exposure.)

SECTION E - PROOF OF PRIOR COVERAGE

Did you or your dependent(s) have major medical coverage with any other carrier(s) within the past 12 months? Yes No
If yes, please attach Certificates of Creditable Coverage from all insurance companies that you have had coverage with for the past 12 months.

SECTION F - COORDINATION OF BENEFITS

Are you or any of your dependents covered under any other health coverage? Yes No
If yes, who is coverage for? Self Spouse Child(ren)
To coordinate claim payment with other health plans, we need information concerning employment and any other health coverage that may be available to your spouse or dependents. We require a yearly update of this information. Payment of your claims may be delayed without current information.

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SECTION G – DEPENDENT INFORMATION: Please list your spouse and eligible child(ren) to be covered

Only list last names for dependents with a <i>different</i> last name than Employee.	Social Security Number	Date of birth (MM-DD-YYYY)	Sex (M/F)	Relationship to you *	Relationship Codes
Spouse's last name, first name, middle initial				S = Spouse	* Use the following codes C=natural/adopted child F=foster child X=step child H=handicapped child S=legally married spouse
Full name(s) of child(ren) (Last, first, middle initial)					
1.					
2.					
3.					
4.					
1. Do you have legal custody of each child to be covered? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Does each child to be covered live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Does each child to be covered receive principal support from you? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Is each child to be covered <i>unmarried</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Is any child to be covered a Full-time Student age 19 or over? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Use this space to comment or provide any other information you feel is pertinent.					

Student Status: Complete for each Dependent child who is a Full-time Student over age 19.

Student name	Semester		Expected graduation year	School name	School City and State	School phone number
	Starts	Ends				

SECTION H – ACKNOWLEDGEMENT, AUTHORIZATION, AND SIGNATURE

1. I certify that the information, statements, and answers on this form, and any attachments, are complete and true to the best of my knowledge. They are a part of this request for coverage under the Group Policy.

2. I apply for myself and any dependents detailed above to join the Destiny Health Plan and agree to adhere to and familiarize myself with the terms of coverage set forth in the Certificate and any amendments, riders, or other materials.

3. I have read, or had read to me, and understand the questions and responses and realize any false statements; omissions and/or material misrepresentation could cause coverage, if issued, to be cancelled as never effective. Any person, who, with intent to defraud or knowing that he or 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.

4. I authorize Group to make deductions from my earnings for my share of the cost, if any, for the benefits to which I may become entitled.

5. I authorize Destiny Health to administer my Personal Medical Fund in accordance with the PMF administration materials.

6. I acknowledge that coverage under the Destiny Health Plan provides the benefits mandated by the State of Illinois.

7. Upon termination of my membership from Destiny Health, I shall repay any amount by which claims were paid by the Personal Medical Fund that exceed cumulative contributions.

8. I authorize Destiny Health to use my social security number when required in connection with treatment, payment, and healthcare operations.

9. **Authorization to Release Medical Information.** I authorize any Medical Professional, hospital, clinic, laboratory, other medical or medically related facility, governmental agency, or other person or firm to provide the Destiny Health Insurance Company ("Company") or their authorized representatives information, including copies of records, and medical, radiological and laboratory testing results, concerning advice, care or treatment provided to me and/or my dependent(s), including without limitation, information relating to mental illness or use of drugs or alcohol.

10. I understand that such information will be used by the Company for the purpose of evaluating my application for health insurance, or by Company representatives involved in evaluating, determining, or administering claims for insurance benefits of me or my dependent(s). I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed through the terms of coverage. A photocopy of this authorization shall be considered as effective and valid as the original.

Employee's signature	Date
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PLEASE RETURN THIS FORM TO YOUR EMPLOYER

STATEMENT OF HEALTH

Please provide the following information for **ALL** individuals (Employee, spouse and child(ren)) for whom coverage is being requested. If more space is needed, attach a separate page giving full details, sign and date each page.

	Name	Height (ft, in)	Weight (Pounds)	Used tobacco in the last 12 months (Yes/No)
Employee				
Spouse				
Child 1				
Child 2				
Child 3				
Child 4				
Child 5				

The following questions (1-6) must be answered for **ALL** individuals (Employee, spouse and child(ren)) for whom coverage is being requested. If any question is answered "yes" please provide details in the additional space provided.

- Is any individual pregnant? yes no
- Has any individual ever been treated or diagnosed by a Physician for Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) infection, AIDS-Related Complex (ARC), or any other immune disorder? yes no
- In the past 5 years, has any individual used illegal drugs or substances not prescribed by a Physician, been advised to have treatment or been treated for drug abuse or chemical dependency, alcoholism, alcohol abuse, alcohol dependency, or been a member of Alcoholics Anonymous? yes no
- Does any person have or has anyone ever had a prosthesis, pacemaker, valve replacement, shunt, or monitoring device? yes no

5. Has any individual ever experienced or been treated for, or is any individual currently suffering from any of the following conditions: (Check either yes or no for each. If yes , underline or circle the applicable condition.)			
a. Mental/Emotional Disorders	eg, Anxiety, depression, schizophrenia, chemical imbalance; any behavioral or emotional disorder; neurosis or psychosis; anorexia or any other eating disorder; mental retardation, deficiency; psychotherapy, marital or any form of counseling or therapy; attention deficit disorder.	<input type="checkbox"/> yes	<input type="checkbox"/> no
b. Central/Peripheral Nervous System	eg, Brain and spinal cord injuries; paralysis; multiple sclerosis; epilepsy; migraines, headaches; carpal tunnel syndrome; any neurological disorder, or any other disorder of the central nervous system	<input type="checkbox"/> yes	<input type="checkbox"/> no
c. Eye or Speech Disorders, or Hearing Impairments	eg, Glaucoma, cataracts, retinal disorder, other visual disorders; hearing or speech impairment; or any other ear, eye, nose, or throat disorder	<input type="checkbox"/> yes	<input type="checkbox"/> no
d. Cardiovascular Disorders	eg, Heart attack or stroke, congestive heart failure, angina, hypertension, cardiomyopathy; heart murmur; chest pain or palpitations; rheumatic fever; mitral valve prolapse; rhythm disturbances; elevated cholesterol or lipids, or any other heart or circulatory disorder or condition	<input type="checkbox"/> yes	<input type="checkbox"/> no
e. Respiratory Disorders	eg, Asthma, difficulty in breathing, shortness of breath, persistent cough, tuberculosis, croup, bronchitis; hemoptysis; emphysema; apnea; chronic obstructive pulmonary disease, or any other respiratory disorder or condition	<input type="checkbox"/> yes	<input type="checkbox"/> no
f. Gastro-Intestinal Disorders	eg, Peptic ulcer; hemorrhoids or rectal disorder, chronic diarrhea; colitis; gastroesophageal reflux; elevated liver function tests, cirrhosis, hepatitis; hernia; change in bowel habits or bleeding; ascites; disorder of the liver, gallbladder, spleen, esophagus or pancreas, or any other digestive disorder	<input type="checkbox"/> yes	<input type="checkbox"/> no
g. Kidney or Urinary Tract Related Disorders	eg, Polycystic kidneys, hematuria, nephritis, prostatitis, nephrectomy, renal failure, renal stones, recurrent urinary tract infection, reflux, urinary incontinence or any other urinary system disorder	<input type="checkbox"/> yes	<input type="checkbox"/> no
h. Male or Female Reproductive System Disorders	eg, Ovarian cysts; menstrual disorders; endometriosis, fibroid or enlarged uterus; abnormal pap smear; infertility; sexually transmitted disease, genital warts, herpes; Peyronie's disease or any other disease or disorder of the genital or reproductive system	<input type="checkbox"/> yes	<input type="checkbox"/> no

5. Has any individual ever experienced or been treated for, or is any individual currently suffering from any of the following conditions: (Check either yes or no for each. <i>If yes</i> , underline or circle the applicable condition.)			
i. Lumps of Growths	Cancer, tumor, growth, cyst, polyp, enlarged lymph nodes	<input type="checkbox"/> yes	<input type="checkbox"/> no
j. Blood Disorders	Anemia, leukemia, bleeding disorders, blood clot, varicose veins or any other blood disorder	<input type="checkbox"/> yes	<input type="checkbox"/> no
k. Endocrine Disorders	eg, Diabetes; hyperthyroidism, thyroiditis, Hashimoto's thyroiditis, goiter, Graves disease, enlargement of the thyroid; Cushing's Syndrome, Addison's syndrome; pituitary or adrenal disorder; or any other endocrine system disease or disorder	<input type="checkbox"/> yes	<input type="checkbox"/> no
l. Connective Tissue and Skin Disorders	eg, Systemic lupus erythematosus; scleroderma; keloid or hypertrophic scars; acne; keratosis; psoriasis; basal cell carcinoma; lesions of the skin or mouth, or any other connective tissue or skin disorder	<input type="checkbox"/> yes	<input type="checkbox"/> no
m. Muscle/Bone Disorders	eg, Arthritis (osteo, rheumatoid, psoriatic); disorders of the spinal structure, herniated, bulging, or slipped disc; bursitis; myasthenia gravis; gout; temporomandibular joint syndrome (TMJ); any injury to, disease or disorder of the spine, back, knees, jaw, bones, muscles, or joints, joint replacement, or manipulation therapy	<input type="checkbox"/> yes	<input type="checkbox"/> no
n. Male or Female Breast	eg, Breast cyst or nodule; gynecomastia, or any other disease or disorder of the breast	<input type="checkbox"/> yes	<input type="checkbox"/> no

6. Has any individual applying for coverage received treatment or been advised to receive treatment or surgery for any physical impairment, deformity, congenital anomaly, sickness, or injury other than admitted above? yes no

Please provide details for all "yes" answers. If more space is needed, attach a separate page giving full details, sign and date each page.

Question Number	Name of person to whom this applies	Diagnosis of illness or condition	Date of diagnosis	Type(s) of treatment(s) including name of medications	Date(s) of treatment(s)	Date of last symptoms or problems

I certify that the information, statements, and answers on this Statement of Health, and any attachments, are complete and true to the best of my knowledge. They are a part of this request for coverage under the Group Policy.	
Employee's signature	Date