The Protect Plans

EMPLOYEE ENROLLMENT FORM
Administered by Meritain Health

Instructions for completing this enrollment form:

- Any eligible employee waiving medical coverage only needs to provide employers name, group number (if known) and employee's name in section 1 and complete and sign the Waiver of Coverage in Section 5.
- This enrollment form must be completed in ink.
- If your employer offers multiple medical plans, please review your options with your employer or broker.

1. Enrollment Information

Employer		Group Number	
Date Employed Full Time	Hours Worked Weekly	Occupation	
Last Name	First Name	M.I.	
Social Security Number	Date of Birth		
Street Address	Apt No.		
(P.O. Box not accepted unless rural P.O. Box)	City	State	Zip
Gender ☐ Male ☐ Female	Height	Weight lbs.	Marital Status ☐ Single ☐ Married
No. of Dependents (including spouse)	Home Phone	Work Phone	

2. Plan Selection & Coverage

Medical Benefit Plans (Select ONE) from among those made available to you by your employer.

Protect Co-Pay Plans

- ☐ Protect 500 Co-Pay (001)
- ☐ Protect 1000 Co-Pay (002)
- ☐ Protect 2000 Co-Pay (003)
- ☐ Protect 3000 Co-Pay (008)
- ☐ Protect 4000 Co-Pay (004)

Protect HSA Plans

- ☐ Protect HSA 3000 (005)
- ☐ Protect HSA 4000 (006)
- ☐ Protect HSA 5000 (007)

3. Eligibility & Other Insurance Information

Currently, are you working full-time? ☐ Yes ☐ No If no, explain: _____

List family members covered by Medicare and their effective date:

Do you or any family members intend to keep other health insurance coverage in addition to this coverage being issued? ☐ Yes ☐ No

If yes, please provide the following information of the other insurance coverage:

Insurance Company Name(s)	Policy Number(s)	Policy Effective Date	Policy Holder Name	List all family members covered
		/ /		
		/ /		
		/ /		
		/ /		

4. Reason for Enrolling or Terminating Coverage

- ☐ Initial Enrollment
- ☐ Court Order
- ☐ Returning to School Full-Time
- ☐ Marriage
- ☐ Birth
- ☐ Special Enrollment/Loss of coverage - Voluntary
- ☐ Divorce
- ☐ Adoption
- ☐ Special Enrollment/Loss of coverage - Involuntary
- ☐ Legal Separation
- ☐ Part/Full Time Change

☐ Terminate coverage for one/all dependents. List dependents who are no longer covered: _____

_____

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

Note: The effective date of your coverage is determined by law or your employer's waiting period.

5. Waiver of Coverage (Please complete if you are declining all coverages for self and/or dependents)

Check all of the following that apply:
I waive 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.

Enrollee Signature _____ Date (required) ____/____/____

6. 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	/ /			/ /	
Child:	☐ M ☐ F	/ /			/ /	
Child:	☐ M ☐ F	/ /			/ /	

7. Required Medical Information

A. Within the past two years, have you or any eligible dependent been diagnosed; had symptoms; had testing completed; had treatment; tested positive; taken medications; or received routine follow up or consultation for any of the following:

- ☐ Acquired Immune Deficiency Syndrome (AIDS)
- ☐ AIDS Related Complex (ARC)
- ☐ HIV
- ☐ Cancer/Tumor
- ☐ Diabetes
- ☐ Heart/Blood/Vascular Disorder/Hypertension
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Hepatitis
- ☐ Respiratory/Lung Disorder
- ☐ Stroke
- ☐ Systemic Lupus/Multiple Sclerosis
- ☐ Organ/Tissue Transplants
- ☐ Immune System Disorder
- ☐ Mental Disorder
- ☐ Alcohol/Drug Abuse
- ☐ Neurological Disorder
- ☐ Birth Defects/Congenital Disorder
- ☐ Arthritis/Back/Joint Disorder
- ☐ Intestinal/Digestive Disorder
- ☐ Infertility

B. Are you or any dependent disabled; hospital confined; pregnant; receiving treatment; taking medication; receiving follow up care; been scheduled for or are awaiting results of any tests, biopsies, procedures or lab work; or been advised of a condition that will require attention in the next twenty-four (24) months? ☐ Yes ☐ No

If pregnant, please provide due date: _____/_____/_____

If pregnant, are you expecting a multiple birth / having complications/ planning a C-Section? ☐ Yes ☐ No

C. Have you or any eligible dependent used tobacco products in the past twelve months? ☐ Yes ☐ No

D. Have you or any eligible dependent ever been declined, postponed, ridered, or rated up for medical, disability or life insurance with another insurance carrier? ☐ Yes ☐ No If yes, please explain.

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).

Name	Illness/Impairment	Dates Treated	Medications/Treatment/Surgery/Treating Physician
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8. 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 (Section 2), 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 90 days from the date of signature.**

Enrollee Signature _____ Date (required) _____/_____/_____

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

_____

9. Signature Required / Authorization to Release Medical Information for Enrollment

We understand the importance of keeping your and your dependents' personal and health information private. To underwrite and service your coverage, we may at times need to share this information as permitted by law and in accordance with your authorization, below, with a health care provider, insurer, insurance support organization, health plan, the Protect Plan program manager or your insurance agent.

I 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 as well as diagnosis, treatment, and testing results related to HIV, AIDS and secually transmitted diseases, 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.

By signing this application you hereby indicate your acceptance of these privacy terms and authorization of permitted disclosure as described.

Enrollee Signature _____ Date (required) _____/_____/_____

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

_____