All Savers

# Employee Enrollment – Alternate Funding

Please send correspondence to P.O. Box 19032, Green Bay, WI 54307-9032 ▪ 1-800-291-2634

**(Please fill out the entire enrollment form to avoid processing delay. Please clearly print all information.)**

**Enrollee Social Security Number** ___ – __ – ____ **Group No.** _____ – ____

## Enrollee Information

| | | | | | | |
|---|---|---|---|---|---|---|
| Employer Name | | | | Employer Address (If more than one location) | | |
| Last Name | | | First Name | | | Initial |
| ❑ Single ❑ Married | Address | City | State | ZIP | County | |
| Phone # | ___ – ___ – ____ | | Gender ☐M ☐F | Date of Birth | Height | Weight |
| Email Address | | | | | | |
| Date Employed Full Time | Average Hours Worked Per Week | Occupation Are you an independent contractor? ☐ Yes ☐ No | | | | |

## Enrollee and Dependent Information (Only for those applying).

If you need to list additional dependents, please use lined paper, sign and date it, and check this box: ☐

| | Enrollee | Spouse | Child 1 | Child 2 | Child 3 |
|---|---|---|---|---|---|
| First Name | | | | | |
| Middle Initial | | | | | |
| Last Name | | | | | |
| Gender | | ☐M ☐F | ☐M ☐F | ☐M ☐F | ☐M ☐F |
| Date of Birth | | / / | / / | / / | / / |
| Height | | | | | |
| Weight | | | | | |
| Social Security Number | | – – | – – | – – | – – |
| Primary Care Physician's Name | | | | | |
| **Eligibility and Other Insurance (insurance that will be kept in addition to this coverage)** | | | | | |
| Currently Working Full Time | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Plan to Keep Other Insurance Coverage | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Other Insurance Policy Number | | | | | |
| Name of Other Insurance Company(ies) | | | | | |
| Covered by Medicare/ Medicaid | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Medicare/Medicaid Coverage Effective Date | | | | | |

## Coverage and Change Request Information

Medical: ☐ Employee ☐ Family ☐ Employee/Spouse ☐ Employee/Dependent Child(ren)

Name of Medical Plan You Have Selected: _____

Change Request: ☐ Marriage ☐ Divorce ☐ Adoption ☐ Returning to School Full Time ☐ Court Order Date of Event: _____
(you may be required to provide proof of event)

Attach a written and signed statement by the employer for a requested coverage effective date other than employee effective date. Effective date may not be guaranteed.



UnitedHealthcare®

## Medical History

Has anyone on this enrollment form been diagnosed, consulted with, or been examined or treated by any health care professional during the last 5 years for any illness, injury, or health condition in any of the categories listed below? If yes, please check the box that most appropriately describes the problem and explain fully below. Please note that, if you leave out or misrepresent information, we may terminate or not renew your coverage, or we may change your monthly payment retroactive to the date your policy became effective. **All statements contained in this entire form must be true and correct and no material information can be withheld or omitted.**

| | |
|---|---|
| 1 Cancer/Tumor<br>☐ Yes ☐ No | ☐ Breast ☐ Colon ☐ Leukemia ☐ Lymphoma ☐ Liver ☐ Lung ☐ Melanoma ☐ Testicular ☐ Brain ☐ Ovarian<br>☐ Cervical ☐ Prostate ☐ Other Cancer ☐ Non-Malignant Tumor – Location of Tumor_____ |
| 2 Heart/Circulatory<br>☐ Yes ☐ No | ☐ Aneurysm ☐ Bypass ☐ Angioplasty/Stent ☐ Congestive Heart Failure ☐ Heart Disease<br>☐ Elevated Cholesterol/Triglycerides ☐ High Blood Pressure ☐ Stroke ☐ Angina ☐ Hemophilia ☐ Blood Clots<br>☐ Pacemaker/ICD ☐ Blood Disorder ☐ Sickle Cell Anemia ☐ Other_____ |
| 3 Reproductive<br>☐ Yes ☐ No | ☐ Current Pregnancy (due date_____ if multiples #_____) ☐ Pregnancy Complications<br>☐ Fibroids ☐ Menstrual Disorders ☐ Breast Disorders ☐ Endometriosis ☐ Infertility<br>☐ Other_____ |
| 4 Intestinal/ Endocrine<br>☐ Yes ☐ No | ☐ Chronic Pancreatitis ☐ Colon Disorder ☐ Crohn's ☐ Ulcerative Colitis ☐ Diabetes ☐ Cirrhosis<br>☐ Hepatitis B/C ☐ Reflux ☐ Liver Disorder ☐ Ulcer ☐ Growth Hormones ☐ Gallbladder ☐ Gastric Bypass<br>☐ Other_____ |
| 5 Brain/Nervous<br>☐ Yes ☐ No | ☐ Alzheimer's ☐ Cerebral Palsy ☐ Migraines ☐ Multiple Sclerosis ☐ Paralysis ☐ Seizures/Epilepsy<br>☐ Parkinson's Disease ☐ Head Injury ☐ Cyst ☐ Other_____ |
| 6 Immune<br>☐ Yes ☐ No | ☐ Scleroderma ☐ ALS ☐ Psoriasis ☐ AIDS ☐ HIV+ ☐ Lupus ☐ Immuno Deficiency<br>☐ Other_____ |
| 7 Lung/Respiratory<br>☐ Yes ☐ No | ☐ Allergies ☐ Asthma ☐ Cystic Fibrosis ☐ Emphysema ☐ Sarcoidosis ☐ Lung Disorders ☐ Tuberculosis<br>☐ Sleep Apnea ☐ Chronic Bronchitis ☐ Pneumonia ☐ Other_____ |
| 8 Eyes/Ears/ Nose/Throat<br>☐ Yes ☐ No | ☐ Acoustic Neuroma ☐ Cataracts ☐ Cleft Lip/Palate ☐ Deviated Septum ☐ Glaucoma ☐ Retinopathy<br>☐ Chronic Ear Infections ☐ Chronic Sinusitis ☐ Other_____ |
| 9 Urinary/Kidney<br>☐ Yes ☐ No | ☐ Kidney Stones ☐ Kidney Disorders ☐ Bladder Disorders ☐ Polycystic Kidney Disease ☐ Prostate Disorder<br>☐ Renal Failure ☐ Other_____ |
| 10 Bones/Muscles<br>☐ Yes ☐ No | ☐ Rheumatoid Arthritis ☐ Osteoarthritis ☐ Bulging/Herniated Disc ☐ Joint injury<br>☐ Fibromyalgia/Chronic Fatigue Syndrome ☐ Chronic Pain Syndrome ☐ Shoulder Disorder ☐ Knee Disorder<br>☐ Spina Bifida ☐ Back Disorder ☐ Neck Disorder ☐ Other_____ |
| 11 Behavioral Health<br>☐ Yes ☐ No | ☐ Anxiety/Depression ☐ ADHD ☐ Bipolar Depression ☐ Manic Depression ☐ Schizophrenia ☐ Autism<br>☐ Eating Disorder ☐ Suicide Attempt ☐ Inpatient Alcohol/Drug ☐ Inpatient Mental Health Hospital<br>☐ Substance Abuse ☐ Other_____ |
| 12 Transplant<br>☐ Yes ☐ No | ☐ Bone Marrow ☐ Organ ☐ Discussed Possible Future Transplant ☐ Stem Cell ☐ Transplant Complications<br>☐ Other_____ |
| 13 Other<br>☐ Yes ☐ No | ☐ Condition not mentioned above with claims in excess of $5,000 ☐ Disability ☐ Congenital Disorder |
| 14 Tobacco<br>☐ Yes ☐ No | ☐ Anyone on this enrollment form used tobacco products in the past 12 months: Person _____ |
| 15 Medications<br>☐ Yes ☐ No | ☐ Current Medications:<br>Person _____ # of Meds ___ Person _____ # of Meds ___ (list meds below)<br>☐ Medications taken within the past 12 months:<br>Person _____ # of Meds ___ Person _____ # of Meds ___ (list meds below) |

Please give details of all "yes" answers above. (If additional space is required, please attach a separate sheet and date and sign that sheet).

| Question # | Person | Condition/Diagnosis | Treatment /Meds | Physician's Name | Dates Treated | Prognosis |
|---|---|---|---|---|---|---|
| | | | | | | |
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## Prior Medical Coverage Information

☐ Yes ☐ No Have you or any dependents applying for coverage been covered by this employer's prior group medical plan?

☐ Yes ☐ No Have you or any dependents applying for coverage been covered by any medical plan other than this employer's prior group plan?
If yes:

Insurance Company Name _____ Phone # _____ Policy/Group #_____

Termination Date _____ Effective Date_____ Reason for Termination _____

Who was covered? _____

Type of Plan: ☐ Prior Employer Group Plan ☐ Spouse's Employer Group Plan ☐ Individual Policy ☐ Other_____

## Signature

I declare all statements contained in this entire form, and in any other health insurance administration and/or coverage application form that I completed within the last 90 days that was provided to All Savers, are true and correct and that no material information has been withheld or omitted. 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 medical benefits will be effective until the date specified in the Summary Plan Description. If I am now waiving medical coverage for myself and/or for my dependents, I have read the entire Waiver provision and understand the enrollment requirements if I make a request for such coverage at a later date.

Coverage is effective only after approval and satisfaction of any probationary period.

In some states, any person who, knowingly and with intent to defraud an insurance company or plan administrator, submits an enrollment form or files a claim containing any materially false information may be guilty of fraud, which is a crime.

All pages must be attached and complete, including this authorization, for the enrollment form to be considered complete. Incomplete enrollment forms may be rejected.

### Authorization to Disclose Medical Information for Enrollment

I hereby authorize those physicians, medical practitioners, hospitals, clinics, veterans administration facilities, pharmacy benefit managers, medical information services, urgent care facilities, and other medical or medically related entities, insurance or reinsurance companies, and consumer reporting agencies that have information available as to the present or former physical health condition, including drug or alcohol abuse, and/or treatment of me or my dependents proposed for coverage to release any and all such information, including, but not limited to, medical records, health care provider notes, laboratory tests and results, diagnoses, treatment, and prognoses. I understand the information obtained by use of this authorization may be used to determine eligibility for issuance of health coverage for me and my dependents. This authorization is not applicable to psychotherapy notes.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall expire 15 months after the termination of any coverage I obtain. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. 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.

Enrollee Signature X _____
Date_____

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

_____

| Waiver (Please complete if you are waiving medical coverage.) | |
|---|---|
| I waive medical coverage for: ☐ Self (and dependents) ☐ Spouse ☐ Dependent Children | Please state 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 plan, 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.

Applicant Signature X _____ Date _____

## YOUR RIGHTS REGARDING THE RELEASE AND USE OF GENETIC INFORMATION

The results of any genetic test, including genetic test information, shall not be used as the basis to (1) terminate, restrict, limit or otherwise apply conditions to the coverage of an individual or family member under the plan, or restrict the sale of the plan to an individual or family member; (2) cancel or refuse to renew the coverage of an individual or family member under the plan; (3) deny coverage or exclude an individual or family member from coverage under the plan; (4) impose a rider that excludes coverage for certain benefits or services under the plan; (5) establish differentials in monthly costs or cost-sharing for coverage under the plan; (6) otherwise discriminate against an individual or family member in the provision of insurance.