EMPLOYEE SELF-FUNDED HEALTH PLAN ENROLLMENT FORM

May be Photocopied or Duplicated for use. Please complete in ink and initial any alterations.

SECTION 1 – EMPLOYEE INFORMATION

FULL NAME OF EMPLOYEE			SOCIAL SECURITY NUMBER	MARITAL STATUS	**ADM. USE ONLY**
RESIDENCE ADDRESS		EMAIL			CASE NO.
CITY	STATE	ZIP	TELEPHONE NUMBER (include area code)	BEST TIME TO CALL	EMPLOYEE NO.
GENDER / DATE OF BIRTH		HEIGHT	WEIGHT	TOBACCO USE ❑ YES ❑ NO	CLASS
DATE BEGAN FULL TIME (mm/dd/yy)	OCCUPATION AND DUTIES			AVG. NO. HOURS WORKED WEEKLY	EFFECTIVE DATE
EMPLOYED BY	CITY	STATE	ZIP		OCC YES ❑ NO ❑
❑ I AM ❑ I AM NOT AN OWNER, PARTNER OR CORPORATE OFFICER					MHX EMPLOYEE & DEPENDENTS YES ❑ NO ❑

I Am Enrolling for (check one): ❑ SELF ONLY ❑ SELF AND SPOUSE ❑ SELF AND CHILD(REN) ❑ SELF, SPOUSE & CHILD(REN)

DEPENDENT WAIVER

If you have dependents (spouse and/or children) and are not enrolling **all** of them, please complete the following:

I AM NOT ENROLLING MY (check one or both): ❑ **SPOUSE** ❑ **CHILD(REN)**

BECAUSE (check one): ❑ Covered by another group/individual health plan ❑ Other (explain) _____

I understand I have the right to enroll my dependents at this time. I am voluntarily declining to enroll my dependents and have not been encouraged or pressured by anyone to decline such coverage. I understand that if I do not enroll my dependents at this time, and they do not have other qualifying coverage, their right to enroll in the future may be restricted, with a delayed effective date.

DEPENDENT INFORMATION **Complete for each dependent to be enrolled (use additional sheet if necessary).**

NAMES OF DEPENDENTS	M/F	RELATIONSHIP	SOCIAL SECURITY NUMBER	DATE OF BIRTH	HEIGHT	WEIGHT	TOBACCO USE	EMAIL & PHONE NUMBER (for spouse and dependents 18 & older)
1.	❑ M ❑ F						❑ YES ❑ NO	
2.	❑ M ❑ F						❑ YES ❑ NO	
3.	❑ M ❑ F						❑ YES ❑ NO	
4.	❑ M ❑ F						❑ YES ❑ NO	

Complete information on all pages in ink. Sign and date last page.

SECTION 2 – MEDICAL INFORMATION

This information is required. Any material misrepresentation or omission may result in termination of your coverage and may constitute fraud. Please answer completely.

Please check "YES" or "NO" for each item and provide details for all "YES" answers in the space provided.

1. In the past 5 years, have you or anyone enrolling for coverage had a diagnosis of or consultation, treatment or medication for:

	YES	NO		YES	NO
Brain or Nervous System	❑	❑	Diabetes or Sugar in Urine	❑	❑
Endocrine or Adrenal Disorder	❑	❑	Digestive/Gastrointestinal Disorder	❑	❑
Liver, Pancreas or Kidney	❑	❑	Breast or Reproductive Organs	❑	❑
Abnormal Blood Pressure	❑	❑	Autoimmune Disorders	❑	❑
Heart or Circulatory System	❑	❑	Disorders of Back or Spine	❑	❑
Chest Pain or Stroke	❑	❑	Rheumatoid Arthritis	❑	❑
Cancer (excluding Basal Cell or Carcinoma)	❑	❑	Emphysema, Tuberculosis or Chronic Obstructive Pulmonary Disease	❑	❑
Disease of the Muscles	❑	❑	Multiple Sclerosis or Cystic Fibrosis	❑	❑
Cirrhosis or Hepatitis	❑	❑	HIV or AIDS	❑	❑
Leukemia or Hodgkin's Disease	❑	❑	Congenital Birth Defects	❑	❑
Hemophilia	❑	❑			

2. Is anyone enrolling for coverage disabled, in any way unable to perform the normal activities of daily living or self care or anticipating surgery or other medical treatment? ..... ❑ YES ❑ NO

3. Are you or any dependent (whether enrolling for coverage or not) currently pregnant, experiencing any complications, or currently receiving infertility testing or treatment? ..... ❑ YES ❑ NO

4. During the past 5 years, has anyone enrolling for coverage visited a doctor, had a medical consultation, had surgery, or been hospitalized for any condition not already indicated above? ..... ❑ YES ❑ NO

Use this space to provide details to any "YES" answer to questions 1 through 4. If you have high blood pressure, please include your last 3 blood pressure readings.

Person	List Medical Conditions and/or specific treatments. Include any anticipated treatment or surgery.	Dates of Treatment	Medications & Dosages	Recovery Status

5. **Is anyone enrolling for coverage currently taking medication (enter details directly below)? ..... ❑ YES ❑ NO**

Person	Medication Name	Generic RX? Yes or No	Dosage & Frequency of Use	Reason for Prescription

If more space is needed use a separate sheet of paper – sign, date and attach any additional pages.

Complete information on all pages in ink. Sign and date last page.

SECTION 3 – EMPLOYEE STATEMENT AND SIGNATURE

I HEREBY: Request enrollment in the self-funded Group Health Plan (Plan) established and maintained by my employer (Employer) for its eligible employees and their eligible dependents; Represent that I am an eligible employee of the Employer; Represent that my statements and answers to the questions in this enrollment form are true and complete to the best of my knowledge and belief; and Authorize the Employer to deduct any required Plan contribution from my earnings.

I FURTHER ACKNOWLEDGE AND UNDERSTAND: This is not an insured benefit plan; All Plan benefits are self-funded (self-insured) by the Employer; The Employer is solely responsible for all benefit payments; Coverage is not effective until the Plan approves this enrollment form; Plan benefits are available only if a person is covered under, and all required contributions for such coverage have been received by, the Plan; If I have waived coverage for a dependent, I also waive all claims under the Plan for benefits for that dependent, and if I decide to enroll that person at a later date, the effective date for my dependent may be delayed. A full description of the medical expense benefits under the Plan appears in the Summary Plan Description, which summarizes the official Plan Document; The agent submitting this enrollment lacks authority to change the enrollment form, approve Plan coverage, alter Plan terms, or adjust claims; The Employer has delegated certain non-fiduciary, ministerial administrative acts, duties and responsibilities of the Plan to Allied National, Inc., a licensed third-party administrator (Allied); However, the Sponsoring Employer remains the Plan Sponsor, Plan Fiduciary, Plan Administrator and Plan Trustee and is responsible for all coverage determinations and benefit payments; Allied does not insure the Plan and is not responsible for funding benefit payments; My statements and answers in this enrollment form will be the basis for approving Plan coverage and any material misrepresentation or omission may result in an increase in Plan contribution rates or termination of my coverage; Any person who, knowingly and with intent to defraud, submits an enrollment form, or files a claim, containing a materially false statement, or omitting materially false information, may be found guilty of fraud in a court of law.

SPECIAL ENROLLMENT RIGHTS: If you acquire a new dependent by marriage, birth, adoption or placement for adoption, he/she may be able to enroll without delay or penalty, if you request enrollment within 31 days (of the marriage, birth, adoption or placement for adoption); If you decline enrollment for any dependent (including your spouse) because of other health plan or group insurance coverage, and that dependent subsequently becomes ineligible for the other coverage (or the employer stops contributing towards that coverage), he/she may be able to enroll without delay or penalty, if you request enrollment within 31 days of ineligibility or termination of employer contributions; If you decline enrollment for any dependent (including your spouse) because of coverage under Medicaid or a State child health plan, and that dependent's coverage is subsequently terminated due to ineligibility, he/she may be able to enroll without delay or penalty, if you request enrollment within 60 days of the termination of coverage; If you decline enrollment for any dependent (including your spouse) and that dependent subsequently becomes eligible for a premium assistance subsidy from Medicaid or a State child health plan, he/she may be able to enroll without delay or penalty, if you request enrollment within 60 days of eligibility for the subsidy. To request special enrollment contact the Employer or Allied Client Services at 800-825-7531.

PERSONAL INFORMATION NOTICE: As required by law, this notice is intended to inform you that 1) Personal information may be collected from third parties; 2) Such information as well as other personal or privileged information collected by the health plan or its legal representative may be in certain instances, as prescribed by law, disclosed to other third parties without your prior authorization; 3) You have the right to access and correct the collected information; 4) Your right to access does not include any information which relates to and is collected in connection with, or in reasonable anticipation of, a claim or civil or criminal proceeding; 5) We will provide a more detailed notice of information practices upon request.

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize the disclosure of all nonpublic personal information and individually identifiable protected health information for me (and my dependent(s), if applicable), including but not limited to employment status, other health plan coverage, diagnosis, prognosis, medical treatment or care, and physical or mental conditions (including alcohol or drug dependency), by any physician, medical practitioner, hospital, other medical related facility, insurance company, employer or benefit plan having such information, to the health plan or its legal representative, agent or vendor, for the purpose of processing enrollment and claims. I acknowledge and agree that this authorization shall be valid for two (2) years; that I may revoke it in writing at any time; that I may request a copy of this authorization; that enrollment, but not the processing of claims, is conditioned on my signing this authorization; that this authorization will be used as its own document, separate from the enrollment form; that a photocopy of this authorization shall be as valid as the original; that any documentation or information disclosed pursuant to this authorization may be re-disclosed and may no longer be covered by federal or state privacy laws; and that I have authority to act as the personal representative of my dependent(s) (if requesting dependent coverage).

Signature of Employee X_____Date _____

Signature of Spouse X _____Date_____