PREFERRED RISK ADMINISTRATORS
YOUR COMPANY - AMPLIFIED

EMPLOYEE ENROLLMENT FORM
For Self-Funded Health Plans

Instructions for completing this enrollment form

1) Each eligible employee enrolling for any coverage offered must complete the entire enrollment form except **Section B**; Section B must be completed only if enrolling in an existing plan or making changes to an existing plan.
2) Any eligible employee waiving all coverages offered only needs to complete and sign the Waiver of Coverage in **Section F**.

Name of Employer: _____

Your Work Address: _____

SECTION A – EMPLOYEE INFORMATION

Employee's Name: _____
Last *First* *MI*

Employee's Mailing Address: _____
Street *City* *State* *Zip*

Home Phone: (_____) _____ Best Time to Call: a.m. p.m. Work Phone: (_____) _____ Best Time to Call: a.m. p.m.

E-mail Address: _____ Are you a U.S. Citizen? ☐ Yes ☐ No Are you a legal resident? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married (Date of Legal Marriage): _____ ☐ Divorced (Date of Legal Divorce): _____

Full-time Employment Date: ____/ ____/ _____ Occupation/Job Duties: _____

Hours worked per week for this employer: _____ Monthly Earnings: $_____

Earnings Basis: ☐ Salaried ☐ Hourly ☐ Commission **Employee Status:** ☐ W2 ☐ 1099 ☐ Owner/Partner ☐ Other *(specify)*:

Current Status: ☐ Currently Working ☐ COBRA ☐ Continuation ☐ Disability ☐ Retired ☐ Other Leave _____

Effective Date of COBRA/Continuation or Other Leave *(MM/DD/YYYY)*: ____/ ____/ _____

SECTION B (Only to be completed by additions to existing groups or for changes to existing coverage.)

Group #: _____ Requested effective date: ____/____/____

This enrollment is for *(check one)*: ☐ New Enrollee ☐ Coverage Change *(specify)* ☐ Adding Spouse ☐ Adding Dependent Coverage

☐ Other Change *(specify type):* _____ # *of Children:* _____

SECTION C – PERSONS TO BE COVERED

(Include yourself and all family members to be insured. If more space is needed, attach an additional sheet and date and initial.)

☐ None ☐ Single: Employee only ☐ Employee & Spouse ☐ Employee & Children ☐ Family: Employee, Spouse & Children

(Include yourself and all family members to be insured) **Last Name** **First Name**	**Relationship & Gender**	**Date of Birth (Mo/Day/Yr)**	**Social Security Number**
	Employee ☐ Male ☐ Female	/ /	— —
	Spouse ☐ Male ☐ Female	/ /	— —
	Child ☐ Male ☐ Female	/ /	— —
	Child ☐ Male ☐ Female	/ /	— —
	Child ☐ Male ☐ Female	/ /	— —

Please explain if any child listed above is (a) not your natural child, legally adopted child or stepchild, (b) not solely supported by you, or (c) not permanently residing in your household. _____

Stop loss insurance for self-funded plans is provided by United Security Life and Health Insurance Company.

SECTION D – WAIVER OF COVERAGE (Complete and sign if waiving any or all coverages for self and/or dependents.)

All eligible employees and dependents must be listed as either enrolling or waiving coverage when first eligible. If you or any of your eligible dependents do not enroll in United Security Life and Health (USL&H) medical coverage when it is first made available and want to enroll in the future, your coverage may be subject to an extended pre-existing period exclusion. This pre-existing exclusion does not apply to maternity benefits.

Person(s) Waiving	Carrier name(s)	ID No.(s)	Effective Date(s)
☐ **Employee**			
☐ **Spouse**			
☐ **Child(ren)**			

Indicate the type of coverage in effect and for whom.

Type of Coverage	For Whom?		
☐ **Spouse's Employer Plan**	☐ Employee	☐ Spouse	☐ Child(ren)
☐ **Medicare / Medicaid**	☐ Employee	☐ Spouse	☐ Child(ren)
☐ **Tricare**	☐ Employee	☐ Spouse	☐ Child(ren)
☐ **COBRA**	☐ Employee	☐ Spouse	☐ Child(ren)
☐ **Individual**	☐ Employee	☐ Spouse	☐ Child(ren)
☐ **Other, explain:**	☐ Employee	☐ Spouse	☐ Child(ren)

Neither I nor my dependents have been induced or pressured to decline coverage by my employer, the agent, or USL&H. I and my dependents have waived such coverage of our own accord.

Signature: _____ **Date of Signature:** _____

Printed Name: _____ Date of **Full-time Employment:** _____

SECTION E – AUTHORIZATION AND SIGNATURE (Required if enrolling for any coverages for self and/or dependents.)

I hereby represent that I am an employee of the participating employer and that the statements and answers to the questions on this enrollment form are true and complete to the best of my knowledge and belief. I understand that the statements and answers contained herein will be used by USL&H to determine eligibility for coverage under the Preferred Risk Administrators Self-Funded Health Plans ("Program") for myself and persons listed on this enrollment form as my spouse or dependent children.

When applicable, I authorize my employer to deduct contributions from my earnings to be applied to the cost of coverage.

I understand that (1) the answers given will be the basis of any coverage provided; (2) coverage, if approved, may be subject to limitations regarding pre-existing conditions as defined by the Summary Plan Description; (3) any material misrepresentation or failure to provide complete information to questions on this enrollment form may be used as a basis for changing rates or terminating my coverage; (4) if coverage is not approved, I, my spouse and/or dependent children are not entitled to benefits; (5) if I, my spouse and/or dependent children waive coverage and decide to apply for coverage at a later date, evidence of eligibility may be required and benefits may be deferred for a specified period of time; and (6) coverage will not be effective until I receive notice that this enrollment form has been approved by USL&H.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, pharmacy or pharmacy-related entity, pharmacy benefits manager (PBM) or PBM-related entity, the Medical Information Bureau, consumer reporting agency, insurance or reinsurance company or employer, having information about me or my minor children to provide all such information as may be requested to USL&H, its legal representative or any medical records retrieval service USL&H may engage, including, but not limited to EMSI.

This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, lab data and EKGs. This information may also be disclosed to any medical records company engaged by USL&H, including but not limited to, EMSI and its agents. Although federal regulation requires that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by USL&H pursuant to this authorization will be protected by federal and state privacy laws and regulations.

Information regarding your eligibility will be treated as confidential. USL&H, or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its Members. If you apply to another bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address in the Bureau's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734, telephone number (866) 692-6901.

I agree that a copy of this authorization will be valid as an original.

I understand that this authorization is required in order to enable USL&H to make eligibility or enrollment determinations relating to me and/or my dependents or for USL&H's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, USL&H may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying USL&H in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: USL&H, 6640 S. Cicero Avenue, Bedford Park, IL 60638. Attention: Privacy Officer. Such revocation will not be valid if USL&H has taken action in reliance on the authorization.

This authorization expires upon the earliest of the following events: denial of my application, declination of enrollment, or, if covered, when I am no longer covered under this Program, but in no event will this authorization be in effect for longer than 24 months from date signed.

Any person who knowingly and with intent to defraud any insurance company or other person submits an enrollment form for coverage or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I understand that the agent submitting this enrollment form represents my interests, not those of USL&H. The agent has no right to bind coverage, to alter the terms of coverage or enrollment form in any manner, or to adjust any claim for benefits. I, or my personal representative, have a right to receive a copy of this enrollment form.

Signature of Employee _____ **Date** _____

PLEASE NOTE: 1) USL&H is not responsible for enrollment forms not sent to us in a timely manner. 2) Effective dates are subject to underwriting approval. 3) Please retain a copy for your records.

********** NOTICE **********

IMPORTANT INFORMATION FOR APPLICANT AND ELIGIBLE DEPENDENTS REGARDING THE PRE-EXISTING CONDITION LIMITATION

This plan contains a pre-existing conditions limitation. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before we will provide coverage for that condition.

This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. If you are in a waiting period for coverage, however, the six-month period ends on the day before the waiting period begins.

The preexisting conditions limitation does not apply to pregnancy, or to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

The exclusion may last up to 18 months if you are a late enrollee from your first day of coverage, or from the first day of your waiting period (if you are in a waiting period). You may, however, be eligible to reduce the length of this exclusion period by the number of days of any prior "creditable coverage." Most prior health coverage is creditable coverage, and can be used to reduce the preexisting conditions limitation if you have not experienced a break in coverage of at least 63 days or more. Otherwise, you and/or dependent(s) will be subject to the full preexisting conditions limitation period.

To reduce the limitation period using your creditable coverage, you should give us a copy of any certificate(s) of creditable coverage you have. If you had prior health coverage, but you do not have a certificate of creditable coverage, you have a right to request one from your prior plan or issuer; or, if necessary, we can help you obtain one from your prior plan or issuer.

All questions about preexisting conditions limitations and creditable coverage should be directed to Preferred Risk Administrators' Customer Service Department at 6640 S. Cicero Avenue, Bedford Park, IL 60638 or Telephone Number 800-875-4422.

INITIAL NOTICE ABOUT SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your, or your dependents', other coverage).

You must, however, request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents.

Effective April 1, 2009 a federal mandate took effect that allows for a Special Enrollment Period, which is outlined below.

A Special Enrollment Period will be provided for an employee and his/her dependent(s) who are eligible, but not enrolled, for coverage under the terms of our plan to enroll for coverage if either of the following conditions are met:

a) The employee or dependent is covered under a Medicaid plan or under a State child health plan and coverage of the employee or dependent under that plan is terminated as a result of loss of eligibility for coverage. The request for coverage under our group health plan must be submitted no later than 60 days following the date of termination of such prior coverage under Medicaid or a State child health plan.

b) The employee or dependent becomes eligible for assistance under a Medicaid plan or under a State child health. The request for coverage under our group health plan must be submitted no later than 60 days following the date of the employee or dependent is determined to be eligible for such assistance.

To request special enrollment, or to obtain more information, please contact Preferred Risk Administrators' Customer Service Department at 800-875-4422.