PREFERRED RISK ADMINISTRATORS
YOUR COMPANY - AMPLIFIED

EMPLOYEE HEALTH QUESTIONNAIRE
For Self-Funded Health Plans

Name of Employer: _____

Your Work Address: _____

SECTION A – 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 B – MEDICAL HISTORY

	Height	**Weight**	**Used any form of tobacco/nicotine in the last 12 months?**
Employee			☐ Yes ☐ No
Spouse			☐ Yes ☐ No

1. List all medications prescribed in the past 18 months for you and any dependents included on this enrollment form. (Include pills, creams, injections, liquids, inhalers, pumps, etc.)

(Complete all columns. If more space is needed, attach an additional sheet of paper which must be signed and dated.)

Individual *(Full Name)*	**Name of Medication**	**Dosage & Frequency of Use**	**Date Prescribed**	**Date Last Used**	**Condition(s) Being Used For**

For all "YES" answers to the following questions, provide full details in SECTION C.

2. Have you or any of your dependents included on this enrollment form within the past *10 years* been diagnosed with or treated for any of the following *(If "Yes", circle all that apply)*: ..... ☐ Yes ☐ No
Cancer/Tumor; Chest Pain; Respiratory/Lung Disorders; Heart Attack/Bypass/Angioplasty; Heart Disorders; Vascular Disorders; Systemic Lupus Erythematosus; Hodgkin's/Lymphoma/Leukemia; Blood Disorders; Immune Disorders; Liver Disorder/Hepatitis; Multiple Sclerosis (MS); Stroke; or Tested Positive or Been Treated for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), Sexually Transmitted Diseases?

3. Have you or any of your dependents included on this enrollment form within the past *5years* been diagnosed with or treated for any of the following *(If "Yes", circle all that apply)*: ..... ☐ Yes ☐ No
Asthma; Back Disorders; Muscle Disorders; Osteoarthritis, Rheumatoid or other Arthritis; Skeletal Disorders; Crohn's Disease; Ulcerative Colitis; Digestive Disorders; Urinary Disorders; Kidney Disorders; Seizures; Paralysis; Nervous System Disorders; Ear/Eye/Nose/Throat Disorders; Reproductive Disorders; Endocrine Disorders; any Other Physical Disorder or Deformity or a Partial or Total Disability?

4. Have you or any of your dependents included on this enrollment form:
   a. Within the past *5years*, been confined in a hospital, residential treatment center, mental health, or medical facility, or had outpatient surgery or had medical expenses in excess of $3,000 in any one year or been absent from work, school, confined to home or incapacitated for more than 2 consecutive weeks due to illness or injury?..... ☐ Yes ☐ No
   b. In the past *18 months*, been seen by any health care provider for emergency services, routine follow-up or ongoing medical care; received consultation, treatment, therapy, advice or undergone any testing? ..... ☐ Yes ☐ No
   c. Been advised of the necessity or possibility of any future hospitalization, treatment, testing or surgery? ..... ☐ Yes ☐ No
   d. Been receiving Workers' Compensation?..... ☐ Yes ☐ No
   If "Yes", provide name and telephone number of claims processor. _____

5. Have you or any of your dependents included on this enrollment form received any treatment, including but not limited to, counseling for alcoholism, or chemical, alcohol or drug abuse or addiction, used illegal drugs or prescription medication other than as prescribed, been advised by a physician to discontinue or decrease alcohol consumption or drug use? ..... ☐ Yes ☐ No

6. Have you or any of your dependents included on this enrollment form been treated for the following conditions, and if "Yes", provide the following information:
   a. Hypertension/High Blood Pressure ..... **☐ Yes ☐ No**
   If "Yes", list last 3 blood pressure readings: Applicant Name _____ Current _____6 mo _____1 yr _____
   Additional Applicant Name _____ Current _____6 mo _____1 yr _____
   b. Diabetes Mellitus (type): ☐ **Type 1 Juvenile Diabetes** ☐ **Type 2 Adult Onset Diabetes** ..... **☐ Yes ☐ No**
   If "Yes", check treatment: ☐ Diet Controlled ☐ Oral Medications ☐ Insulin ☐ Insulin Pump
   Date of onset: _____/_____/_____
   Include your last Hemoglobin A1c Reading and Date: _____ _____/_____/_____
   c. Diabetic Related Disorders *(If "Yes", circle all that apply)*..... **☐ Yes ☐ No**
   Heart Disease, Stroke, Kidney Impairments (Nephropathy), Visual Impairments (Retinopathy), Peripheral Vascular Disease, Nerve Impairments such as Numbness or Burning of Legs or Feet (Neuropathy)
   d. Mental, Nervous or Behavioral Disorders ..... **☐ Yes ☐ No**
   Diagnosis: _____
   Treatment *(If "Yes", circle all that apply)*: Inpatient Treatment, Outpatient Treatment, Counseling, Prescription Medication(s)

7. Are you or any dependents included on this enrollment form currently pregnant, an expectant parent, in the process of adoption, undergoing or have undergone infertility treatment?..... ☐ Yes ☐ No

   Are you anticipating complications for you or your unborn child and/or multiple births? ..... ☐ Yes ☐ No

   Are you anticipating a cesarean section? ..... ☐ Yes ☐ No

   Due Date: _____/_____/_____ Date of Adoption: _____/_____/_____

SECTION C — MEDICAL HISTORY DETAILS (Details for all answers marked "YES" must be provided below.)

(Complete all columns. If more space is needed, attach an additional sheet of paper which must be signed and dated.)

Question # and Letter	Individual *(Full Name)*	Diagnosis and/or Condition	Dates of Diagnosis and/or Condition	Explain Treatment Include any Hospitalization, Tests or Surgery	Results/Degree of Recovery and Current Status	Physician/ Specialty/ Hospital Telephone Number

SECTION D — 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 copy for your records.