

## EMPLOYEE ENROLLMENT/CHANGE FORM

WITH Individual Medical Questions

NOTICE: A person who knowingly and with intent to defraud files an application or statement of claim

containing any false, incomplete or misleading information may be guilty of fraud, which is a crime.

I understand and agree to answer all questions and complete all requested information thoroughly



Administrative Services by: SISCO 800 Main Street | PO Box 389 Dubuque, IA 52004-0389 Phone: 563.587.5424 Fax: 563.587.5722



Marketed Exclusively by: Benefit Indemnity Corporation 303 W Allegheny Avenue Towson, MD 21204

and truthfully. I understand that failure to do so may result in loss of coverage or denial of claims for any or all of those persons included on this application. Phone: 443.275.7400 www.benefitindemnity.co ➤ Each eligible employee must complete the entire form. ➤ This enrollment form must be completed in blue or black ink. Please choose from the following: New Applicant Coverage Change Information Update COBRA Applicant Add/Drop Dependent PLEASE FILL OUT THE ENTIRE APPLICATION TO AVOID PROCESSING DELAY. Group #: Applicant Social Security Number: - \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Employer Name: Division and/or Location: APPLICANT Last Name: \_\_\_\_\_ First Name: \_\_\_\_ Middle Initial: \_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: 🗖 Male 📮 Female Height: \_\_\_\_\_ Ft. \_\_\_\_ In. Weight: \_\_\_\_\_ Lbs. Marital Status: ☐ Single ☐ Married Have you or any eligible dependent used tobacco products in the past twelve (12) months? ☐ Yes ☐ No Home or Mobile Phone: Work Phone: Occupation: Email Address: Please indicate the number of hours worked weekly on a regular basis for this emplover: FAMILY INFORMATION (PLEASE COMPLETE FOR ALL PERSONS TO BE COVERED BY THE HEALTH PLAN) First Name & M.I. (last name if different) Gender Date of Birth Weight **Email Address** Height Social Security No. Spouse  $\square$  M  $\square$  F 1 1 Child  $\square$  M  $\square$  F 1 1 1 1  $\square$  M  $\square$  F Child 1 1  $\square$  M  $\square$  F Child 1 1  $\square$  M  $\square$  F COVERAGE INFORMATION Medical: ☐ Employee ☐ Family ☐ Employee/Spouse ☐ Employee/Child(ren) Requested Effective Date: PLEASE BE SURE YOUR COVERAGE LEVEL SELECTED COORDINATES WITH THE DEPENDENT INFORMATION YOU PROVIDED ABOVE. Medical Plan Selection: Do you have other coverage that will remain in place along with this coverage? ☐ Yes ☐ No (If YES, provide additional info/copy of ID card.)

Employee

☐ Family

Dental:

■ Employee/Child(ren)

■ NONE

■ Employee/Spouse

REQUIRED MED	DICAL INFORMATION				
QUESTIONS 1 THROUG	H 4 TO BE ANSWERED BY EMPLOYEE, SP	OUSE AND ALL DEPENDENTS DESIF	RING COVERAGE.		
			use and/or any child) to be covered in the	-	
diagno		agnostic tests, biopsies or lab w	tt, received follow up care, scheduled office vi- ork, or been advised of a condition that is rec		☐ Yes ☐ No
	your spouse (whether covered on th				☐ Yes ☐ No
If Yes	Due Date:		u expecting twins or another multiple birth?	☐ Yes ☐ No	
	Are you having any complications?	☐ Yes ☐ No	Are you planning a C-Section?	☐ Yes ☐ No	
3. Have you o		declined, postponed, ridered,	or rated up for medical, disability or life in	surance with any	☐ Yes ☐ No
4. In the past counseling		ole dependent to be covered h	ad any symptoms, diagnosis, consultation	, testing, treatment, follow-up car	re, or taken any medication or received
	th blood pressure, hypertension or hea	rt condition?			☐ Yes ☐ No
b. Psychological disorder, substance use disorder, ADD or ADHD?					☐ Yes ☐ No
c. Back or Neck Pain, arthritis, joint or muscular disorder?					☐ Yes ☐ No
d. Asthma, emphysema, respiratory or lung disorder?					☐ Yes ☐ No
e. Cir	culatory, Vascular, Endocrine or blood	disorder?			☐ Yes ☐ No
	urological disorder or stroke?				☐ Yes ☐ No
	mor (benign, malignant or otherwise), (	Cancer?			☐ Yes ☐ No
	abetes or kidney disorder?				☐ Yes ☐ No
		Immune Deficiency Syndrome	(AIDS) or AIDS Related Complex (ARC)?		☐ Yes ☐ No
	rious or Systemic Infection?				☐ Yes ☐ No
	ngenital Disorder/Birth Defects?				☐ Yes ☐ No
	patitis or Liver Disorder?				☐ Yes ☐ No
	pestive system disorder? pus or Multiple Sclerosis?				☐ Yes ☐ No ☐ Yes ☐ No
	ertility or Reproductive system / genitou	urinany system disorder?			☐ Yes ☐ No
					☐ Yes ☐ No
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	gan/Tissue transplant (whether donatin	<u> </u>	ast doctor visit and/or examination and all	medication taken (if more space is	
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