


The following 18 pages provide an overview to [www.InstantEnroll.com](http://www.InstantEnroll.com):



**INSTANT ENROLL**  
An Online Health Enrollment Application

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This is the first page the employee sees after entering their password and user ID. The employee must select "I Agree" and click the "Proceed" button to continue.

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### Welcome to Instant Underwriter

This system allows you to fill out the information insurance companies require from individuals and their dependents who are applying for coverage. It is designed to make it easier for you to collect the necessary information and complete all the required insurance forms. It is not a substitute for your personal review and accurate entry of information. Before starting the application process, please read the following carefully.

1. The application requires detailed information on you and your dependents such as Social Security numbers, current or previous coverage contact information and policy number(s), and coverage dates.
2. The application also requires detailed information on any medical condition and/or medications for you and your dependents. Before you start this application, it would be helpful to collect dates of onset and/or recovery relating to medical conditions, medication names, dosage amounts, refill amounts, and other pertinent information.
3. If, for any reason, you cannot locate the appropriate field(s) to enter information in the online application, please contact your broker to discuss the best way to address this situation. You also may enter this information in the Additional Information field on the Review Page at the end of the application.
4. At any time, you may save the application and continue at a later time if needed.
5. At the top and bottom of each page, there are "Previous" and "Continue" navigation buttons you use to go back or forward to each page. Use the navigation links on the left hand side of the page to print and view the insurance company applications and manage your passwords.
6. You are required to provide accurate, complete, truthful, and not misleading information.
7. After you have completed the application, your information will be transferred into the insurance companies' forms. It is your responsibility to review each application and confirm that the information is accurate, complete, and truthful. You can do this by using the Preview button beside each application.
8. After you have fully reviewed each application, you will need to print out and sign the applications. Then, return the applications to your HR administrator in a sealed envelope. You must use Adobe Acrobat Reader 6.0 in order to print the applications. If you do not have Adobe 6.0 installed on your computer, click on the Get Acrobat Reader button below to go to the Adobe website for the free download of the program.

If you have already completed your questionnaire and simply need to print or reprint your form(s) please click on the "Print Application" link in the upper left hand corner.

THIS AGREEMENT CONSTITUTES A LEGAL CONTRACT BETWEEN YOU AND YOUR EMPLOYER AND GOVERNS YOUR ACCESS TO AND USE OF THE FORM WRITING SYSTEM NOTED BELOW IN ANY MANNER.

IF YOU HAVE BEEN GRANTED THE RIGHT TO ACCESS AND USE THIS SYSTEM IN YOUR CAPACITY AS AN EMPLOYEE OR REPRESENTATIVE OF A LEGAL ENTITY, THEN (1) BOTH YOU (AS AN INDIVIDUAL) AND THE APPLICABLE LEGAL ENTITY ARE BOUND BY THIS AGREEMENT, (2) YOU HAVE THE APPROPRIATE RIGHTS AND AUTHORITY TO ENTER INTO AND BIND YOU AND THE APPLICABLE LEGAL ENTITY TO THE TERMS OF THIS AGREEMENT, AND (3) ALL REFERENCES IN THIS AGREEMENT TO "YOU" AND "YOUR" INCLUDE YOU (AS AN INDIVIDUAL) AND SUCH LEGAL ENTITY.

IF YOU HAVE BEEN GRANTED THE RIGHT TO ACCESS AND USE THIS SITE AS AN INDIVIDUAL AND NOT AS AN EMPLOYEE OR REPRESENTATIVE OF A LEGAL ENTITY, THEN (1) YOU (AS AN INDIVIDUAL) ARE AGREEING TO BE BOUND BY ALL OF THE TERMS AND CONDITIONS CONTAINED IN THIS AGREEMENT, AND (2) ALL REFERENCES IN THIS AGREEMENT TO "YOU" AND "YOUR" REFER TO YOU PERSONALLY.

THIS IS A FORM WRITING SYSTEM ONLY. IT IS NOT DESIGNED AS A FULL MEDICAL UNDERWRITING PROGRAM. YOU ARE REQUIRED TO REVIEW AND PRINT THE INSURANCE CARRIER FORM(S), THEN SIGN AND SUBMIT THEM TO YOUR EMPLOYER OR BROKER.

The insurance company(ies) are responsible for medical underwriting. You understand that your application for coverage is on the basis of these statements and answers to the questions. You understand that these statements, answers, and subsequent information you provide are the basis for your coverage.

You understand that all information provided by you in this application must be truthful, accurate, complete, and up-to-date. You represent and warrant that you have provided and will provide truthful, accurate, complete and up-to-date registration information in this application. You understand that you must update the information in this application to include any condition or disease that may occur between the date of your application and the Effective Date of Coverage. You understand that if your application for new or additional coverage is accepted, that applicable coverage will not be effective until after you are notified of the Effective Date.

UPON COMPLETION, YOU HEREBY DECLARE ALL ANSWERS TO BE TRUE, ACCURATE, COMPLETE AND UP-TO-DATE TO THE BEST OF YOUR KNOWLEDGE AND TO ACCURATELY REPRESENT THE HEALTH OF THOSE PERSONS APPLYING FOR COVERAGE OR VARIING COVERAGE. YOU UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMITTING RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIM(S) OR CANCELLATION OF COVERAGE FOR YOU AND/OR YOUR DEPENDENTS. IT IS THE RESPONSIBILITY OF THE APPLICANT TO CAREFULLY REVIEW EACH PRINTED APPLICATION AND CONFIRM THAT THE INFORMATION IS TRUE, COMPLETE, ACCURATE AND UP-TO-DATE.

I agree  I disagree

After the employee selects "I Agree" and clicks the "Proceed" button, they can continue.

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The employee must complete the required fields.  
 If the broker has uploaded the census, much of this information is already populated for the employee.

### Employee Information

Please enter your information. Required fields are marked in yellow.

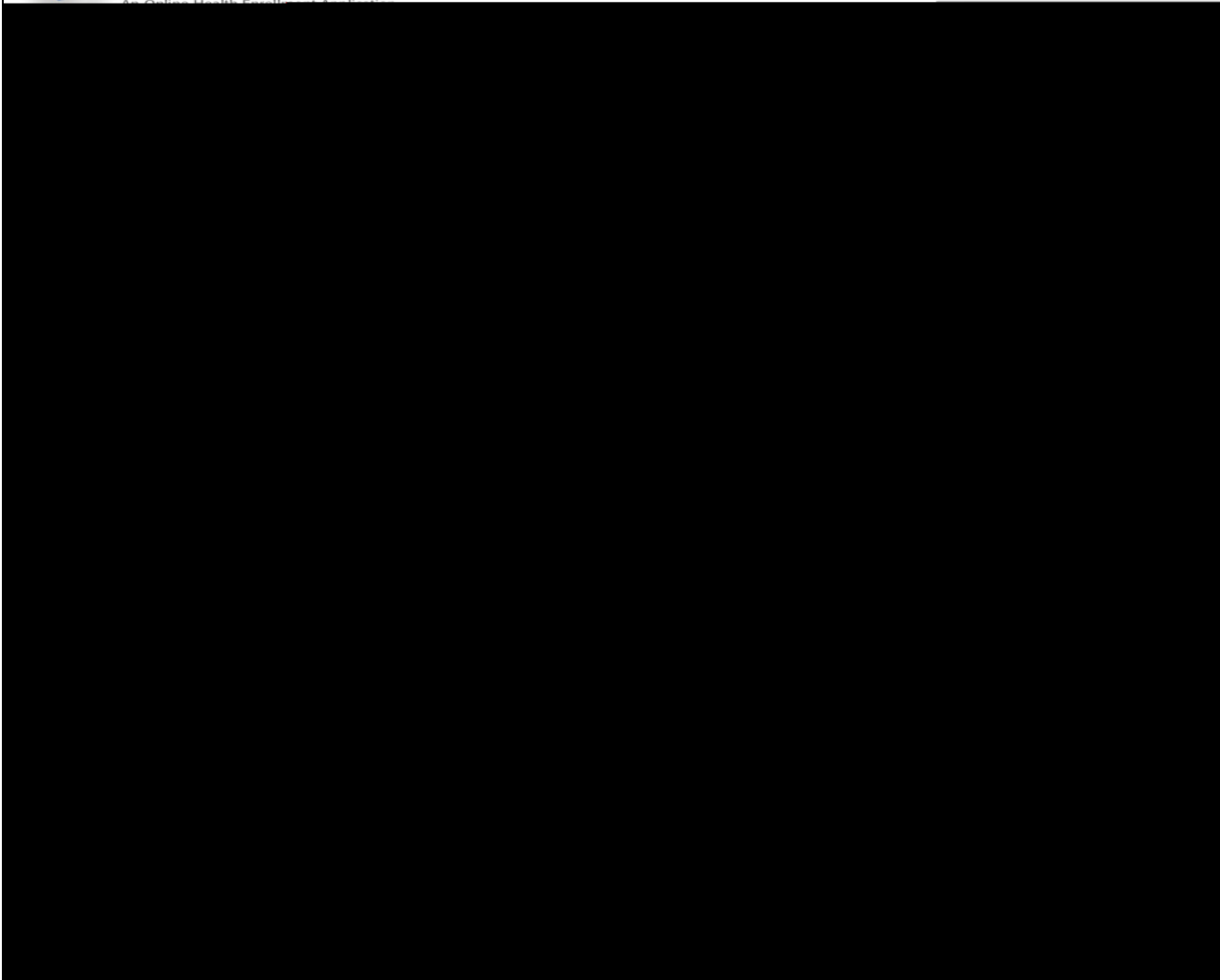
#### Enrollment Information

Employer:   
 Reason for Enrollment:   
 Effective Date:

#### Employee Information

|                                                                                  |                                             |                                         |                                        |                                         |                                         |
|----------------------------------------------------------------------------------|---------------------------------------------|-----------------------------------------|----------------------------------------|-----------------------------------------|-----------------------------------------|
| Social Security Number                                                           | Birth Date                                  | Birth State                             | Gender                                 | Marital Status                          | Marital Event Date                      |
| <input type="text" value="125654587"/>                                           | <input type="text" value="10/14/1983"/>     | <input type="text" value="Other"/>      | <input type="text" value="Male"/>      | <input type="text" value="Married"/>    | <input type="text" value="01/01/2000"/> |
| First Name                                                                       |                                             | Middle Initial                          | Last Name                              |                                         |                                         |
| <input type="text" value="John"/>                                                |                                             | <input type="text" value="r"/>          | <input type="text" value="doe"/>       |                                         |                                         |
| Address                                                                          |                                             |                                         |                                        |                                         |                                         |
| <input type="text" value="123 east harbor rd"/>                                  |                                             |                                         |                                        |                                         |                                         |
| <input type="text" value=""/>                                                    |                                             |                                         |                                        |                                         |                                         |
| City                                                                             |                                             |                                         |                                        |                                         |                                         |
| <input type="text" value="spokane"/>                                             | St                                          | Zip                                     | County                                 |                                         |                                         |
|                                                                                  | <input type="text" value="WA"/>             | <input type="text" value="99207"/>      | <input type="text" value="spokane"/>   |                                         |                                         |
| E-Mail                                                                           |                                             |                                         |                                        |                                         |                                         |
| <input type="text" value="johnr@instantbenefits.com"/>                           |                                             |                                         |                                        |                                         |                                         |
| Home Phone                                                                       | Work Phone & Ext                            | Mobile Phone                            | Fax                                    |                                         |                                         |
| <input type="text" value="2538528352"/>                                          | <input type="text" value="4521586521"/>     | <input type="text" value=""/>           | <input type="text" value=""/>          |                                         |                                         |
| Height                                                                           | Weight                                      | Do you have dependent children?         |                                        |                                         |                                         |
| <input type="text" value="5'8"/>                                                 | <input type="text" value="140"/>            | <input type="text" value="Yes"/>        |                                        |                                         |                                         |
| If you speak a language other than English as a primary language, please specify |                                             |                                         |                                        |                                         |                                         |
| <input type="text" value=""/>                                                    |                                             |                                         |                                        |                                         |                                         |
|                                                                                  |                                             |                                         |                                        |                                         |                                         |
| Are you an Owner/Officer?                                                        | Occupation, Job Title, or Duties            | Hire Date                               | Employment Status                      | Full-time Employment Date               |                                         |
| <input type="text" value="Yes"/>                                                 | <input type="text" value="system analyst"/> | <input type="text" value="10/13/2006"/> | <input type="text" value="Full Time"/> | <input type="text" value="10/14/2006"/> |                                         |
| Hours Worked per Week                                                            | Salary                                      | Salary Cycle                            |                                        |                                         |                                         |
| <input type="text" value="40"/>                                                  | <input type="text" value="40000"/>          | <input type="text" value="Hourly"/>     |                                        |                                         |                                         |

The employee must fill out all required fields.



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The employee must indicate if they are applying or waiving coverage for themselves or their dependents.

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**Benefit Selection**

Select the coverages you would like to enroll for yourself and dependents.

I am applying for coverage for: (check all that apply)

|         |                                            |                                               |                                                   |
|---------|--------------------------------------------|-----------------------------------------------|---------------------------------------------------|
| Medical | <input checked="" type="checkbox"/> Myself | <input checked="" type="checkbox"/> My Spouse | <input type="checkbox"/> My Dependents            |
| Dental  | <input checked="" type="checkbox"/> Myself | <input type="checkbox"/> My Spouse            | <input checked="" type="checkbox"/> My Dependents |
| Vision  | <input checked="" type="checkbox"/> Myself | <input checked="" type="checkbox"/> My Spouse | <input checked="" type="checkbox"/> My Dependents |

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If the employee waives coverage for any family member, the system requires that they select the waiver reason. If all family members are enrolling, this page is skipped.

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### Enrollment Status

Listed below are your benefit selections. If you chose to enroll you and/or your dependents, the form will display your selection. If you chose to waive coverage for you and/or your dependents, please verify that you do not want to enroll by checkmarking the boxes and selecting the appropriate reason(s) for waiving coverage in the provided dropdown boxes.

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| Type of Coverage | Coverage for Myself | Coverage for My Spouse                                                                            | Coverage for My Dependents                                                                          |
|------------------|---------------------|---------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| Medical          | Enrolled            | Enrolled                                                                                          | Enrolled                                                                                            |
| Dental           | Enrolled            | Enrolled                                                                                          | <input checked="" type="checkbox"/> Waiving coverage for my dependents because<br>Individual Policy |
| Vision           | Enrolled            | <input checked="" type="checkbox"/> Waiving coverage for my spouse because<br>Spouse's Group Plan | <input checked="" type="checkbox"/> Waiving coverage for my dependents because<br>Cost              |

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If the employee has indicated they are married or have dependent children, they will be required to enter this information here.

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### Dependents

To add each dependent, complete the required fields with an asterisk and click the Add Dependent button before you continue.

If applicable, you will be required to add a spouse or domestic partner in this section. If you indicated you had a dependent child and you had not indicated you were required to add at least one dependent child in this section.

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| Name                            | Relation    | Select                   |
|---------------------------------|-------------|--------------------------|
| <a href="#">Add Spouse</a>      | Spouse      | <input type="checkbox"/> |
| <a href="#">Add Child</a>       | Child       | <input type="checkbox"/> |
| <a href="#">Add Parent</a>      | Parent      | <input type="checkbox"/> |
| <a href="#">Add Grandchild</a>  | Grandchild  | <input type="checkbox"/> |
| <a href="#">Add Grandparent</a> | Grandparent | <input type="checkbox"/> |
| <a href="#">Add Sibling</a>     | Sibling     | <input type="checkbox"/> |
| <a href="#">Add Other</a>       | Other       | <input type="checkbox"/> |

First Name \*  ID \*  Last Name \*  Gender \*  Relation \*   
 Birth Date \*  Birth State \*  SSN \*  Height \*  Weight \*   
 If last name differs from employee, please explain:   
 If dependent is age 19+, indicate student status:  Student  Grad Date:   
 If this dependent speaks a language other than English as a primary language, please specify:   
 Does this dependent reside at a different address than the employee?  
 If yes, please give address:  Do you want dependent materials to be mailed to this address?

Add Dependent

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If the the assigned app has any specific questions, they can be answed here.

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### Carrier Application Questions

Some carriers may require additional applicant information. Please answer all of the following questions. Questions that don't apply can be marked 'NA'. Once all questions are answered, click "Continue" to continue the application.

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Change current enrollment because of the following events:

|                                       |                                    |
|---------------------------------------|------------------------------------|
| Marriage?                             | <input type="button" value="Yes"/> |
| Divorce?                              | <input type="button" value="No"/>  |
| Birth?                                | <input type="button" value="No"/>  |
| Involuntary loss of coverage?         | <input type="button" value="No"/>  |
| Death?                                | <input type="button" value="No"/>  |
| Court order (copy of order required)? | <input type="button" value="No"/>  |
| Adoption                              | <input type="button" value="No"/>  |
| Other?                                | <input type="button" value="No"/>  |

If other, explain event:

Date event occurred:

Has any insurance carrier refused, restricted (including waiver or condition), or rated any health coverage for you or any dependents listed on this application?

If yes, please explain (list applicant's name, medical condition and whether refusal, waiver, or restriction):

If yes, name of carrier:

If yes, refusal date:

Is your employer contributing toward this coverage?

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The Employee checks which categories of conditions they have.

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**Health Categories**

Have any covered members ever been treated for or diagnosed with any of the following conditions?  
Please answer the following health category questions to the best of your knowledge by selecting either yes or no. For each "yes" answer given on this page, you will then need to select the specific condition(s) for that category on the following page. You may read through some of the related conditions for each category and follow the link to get a full list of all related conditions if not sure.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>1. Cancer/Neoplasms</b><br/>Examples of conditions for this category include but are not limited to: Abnormal Growth, Benign Tumor, Breast Cancer, Other related disease, disorder or problem, Colon Cancer, Cervical Cancer, Leukemia, Liver Cancer, Lung Cancer, Malignant Tumor, Sarcoma. Please refer to the following link for a comprehensive list for all conditions relating to <a href="#">Neoplasms</a>. Also refer to this site regarding <a href="#">Cancers</a>.</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> | <p><b>2. Infectious/Parasitic Diseases</b><br/>Examples of conditions for this category include but are not limited to: bone infection, HIV, Sexually Transmitted Disease, Other related disease, disorder or problem, Polio. For a comprehensive list for all conditions, please click on the following link relating to <a href="#">Infectious/Parasitic Diseases</a>.</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>                                                                                                                                  |
| <p><b>3. Endocrine/Metabolic/Immune System</b><br/>Examples of conditions for this category include but are not limited to: AIDS Related Complex, Diabetes, Gout, Other related disease, disorder or problem, Growth Disorder, Immune Deficiency Disorder, Pancreas Disorder. Please refer to the following link for a comprehensive list for all conditions relating to <a href="#">Endocrine/Metabolic/Immune System</a>.</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>                                                         | <p><b>4. Blood Diseases and Disorders</b><br/>Examples of conditions for this category include but are not limited to: Anemia, Other related disease, disorder or problem, Hemophilia, Sickle-cell trait, Thrombocytopenia, Erythrocytosis, abnormal white blood cells. For a comprehensive list for all conditions, please refer to the following link relating to <a href="#">Blood Diseases and Disorders</a>.</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>                                                                                         |
| <p><b>5. Mental Health/Chemical Dependency</b><br/>Examples of conditions for this category include but are not limited to: Addicted to Drug Treatment, Alcohol Use, Alcohol Abuse, Other related disease, disorder or problem, Depression, Drug Use, Eating Disorder, Schizophrenia, Suicide-attempt. For a comprehensive list for all conditions, please click on the following link relating to <a href="#">Mental Health/Chemical Dependency</a>.</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>                               | <p><b>6. Brain/Neurological/Central Nervous System</b><br/>Examples of conditions for this category include but are not limited to: Alzheimer's Disease, Autism, Other related disease, disorder or problem, Central Nervous System Disorder, Concussion, Epilepsy, Fainting Spells, Headaches, Learning Disability, Migraine, Multiple Sclerosis. For a comprehensive list for all conditions, please click on the following link relating to <a href="#">Brain/Neurological/Central Nervous System</a>.</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> |
| <p><b>7. Heart/Circulatory System</b><br/>Examples of conditions for this category include but are not limited to: Blood Clot, Chest Pain, Heart Attack, Heart Disorder, Other related disease, disorder or problem, Heart Murmur, High Blood Pressure, High Cholesterol, Low Blood Pressure, Phlebitis, Stroke. Please click on the following link for a comprehensive list for all conditions relating to <a href="#">Heart/Circulatory System</a>.</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>                               | <p><b>8. Respiratory System</b><br/>Examples of conditions for this category include but are not limited to: Allergy, Asthma, Blood Spitting, Bronchitis, Emphysema, Other related disease, disorder or problem, Pleurisy, Pneumonia, Shortness of Breath, Common cold, Tonsillitis, Whooping Cough, Respiratory Infection, Cough variant asthma. For a comprehensive list for all conditions, please click on the following link relating to <a href="#">Respiratory System</a>.</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>                         |
| <p><b>9. Digestive/Intestinal System</b><br/>Examples of conditions for this category include but are not limited to: Chronic Diarrhea, Crohn's Disease, Glaucoma, Irritable Bowel Disease, Jaundice, Liver Disorder, Intestinal Disorder, Stomach Disorder, Other related disease, disorder or problem, Stomach Staping, Ulcer. For a comprehensive list for all conditions, please click on the following link relating to <a href="#">Digestive/Intestinal System</a>.</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>           | <p><b>10. Urinary System</b><br/>Examples of conditions for this category include but are not limited to: Kidney Disorder, Bladder Disorder, Kidney Stones, Neurogenic Bladder, Polycystic Kidney Disease, Kidney Failure, Urinary Incontinence, Urinary Tract Disorder, and other related disease, disorder or problem. For a comprehensive list for all conditions, please click on the following link relating to <a href="#">Urinary System</a>.</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>                                                      |
| <p><b>11. Pregnancy/Reproductive System</b><br/>Examples of conditions for this category include but are not limited to: abnormal Pap Smear, Other related disease, disorder or problem, Cervicitis, Pregnant, Infertility, irregular Bleeding, Miscarriage, Premature Birth, Breast Disorder. For a comprehensive list for all conditions, please click on the following link relating to <a href="#">Pregnancy/Reproductive System</a>.</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>                                           | <p><b>12. Skin Diseases and Disorders</b><br/>Examples of conditions for this category include but are not limited to: Allergy, Other related disease, disorder or problem, Skin Disorder, Skin Ulcer, Eczema. For a comprehensive list for all conditions, please click on the following link relating to <a href="#">Skin Diseases and Disorders</a>.</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>                                                                                                                                                   |
| <p><b>13. Musculoskeletal System</b><br/>Examples of conditions for this category include but are not limited to: Arthritis, Back Disorder, Bone Disorder, Joint Disorder, Joint Replacement, Neck Disorder, Ruptured Disc, Other related disease, disorder or problem, Spinal Disorder. Please click on the following link for a comprehensive list for all conditions relating to <a href="#">Musculoskeletal System</a>.</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>                                                         | <p><b>14. Congenital/Birth Conditions</b><br/>Examples of conditions for this category include but are not limited to: Clift Lip, Clift Palate, Congenital Heart Condition, Congenital Deafness, Other related disease, disorder or problem, Down's Syndrome, Low Birth Weight Related Condition. Please click on the following link for a comprehensive list for all conditions relating to <a href="#">Congenital/Birth Conditions</a>. You may also refer to <a href="#">Neurology</a>.</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>                |
| <p><b>15. Transplants/Implants</b><br/>Examples of conditions for this category include but are not limited to: Breast Implant, Considered for Transplant, Prosthetic Device, Replaced Implant, Other Kidney Transplant, Liver Transplant, Blood and Marrow Transplants.</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>                                                                                                                                                                                                            | <p><b>15. Transplants/Implants</b><br/>Examples of conditions for this category include but are not limited to: Breast Implant, Considered for Transplant, Prosthetic Device, Replaced Implant, Other Kidney Transplant, Liver Transplant, Blood and Marrow Transplants.</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>                                                                                                                                                                                                                                  |

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The Employee checks which conditions they have for each category chosen.

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### Health Conditions

Have any covered members ever been treated for or diagnosed with any of the following conditions?

Check off all related conditions for each category that you said "yes" to on the prior page. You will then have a chance to fill out some details relating to that condition on the next page.

You must select at least one condition for each displayed category.

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---

**Skin Diseases and Disorders**

|                                                                                                                                                        |                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Allergy<br><input type="checkbox"/> Other skin disease, disorder or problem<br><input type="checkbox"/> Skin Ulcer | <input type="checkbox"/> Eczema<br><input type="checkbox"/> Skin Disorder |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|

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**Musculoskeletal System**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Ankylosing Spondylitis<br><input type="checkbox"/> Back Disorder<br><input type="checkbox"/> Bone Infection<br><input type="checkbox"/> Connective Tissue Disorder<br><input type="checkbox"/> Herniated Disc<br><input type="checkbox"/> Joint Replacement<br><input type="checkbox"/> Kyphosis<br><input type="checkbox"/> Muscular Dystrophy<br><input type="checkbox"/> Osteoarthritis<br><input type="checkbox"/> Osteoporosis<br><input type="checkbox"/> Paralysis<br><input type="checkbox"/> Ruptured Disc<br><input type="checkbox"/> Spinal Disorder<br><input type="checkbox"/> Spondylolisthesis<br><input type="checkbox"/> Temporo-Mandibular Joint (TMJ) | <input type="checkbox"/> Arthritis<br><input type="checkbox"/> Bone Disorder<br><input type="checkbox"/> Carpal Tunnel<br><input type="checkbox"/> Fibromyalgia<br><input type="checkbox"/> Joint Disorder<br><input type="checkbox"/> Knee Disorder<br><input type="checkbox"/> Muscle Disorder<br><input type="checkbox"/> Neck Disorder<br><input type="checkbox"/> Osteogenesis Imperfecta<br><input type="checkbox"/> Other musculoskeletal disease, disorder or problem<br><input type="checkbox"/> Rheumatoid Arthritis<br><input type="checkbox"/> Scoliosis<br><input type="checkbox"/> Spinal Stenosis<br><input type="checkbox"/> Spondylosis<br><input type="checkbox"/> Tendonitis |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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**Other Symptoms, Signs and Injuries**

|                                                                                                     |                                                                                              |
|-----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Abnormal Test Result<br><input type="checkbox"/> Advised Further Treatment | <input type="checkbox"/> Advised Further Testing<br><input type="checkbox"/> Advised Surgery |
|-----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|

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The Employee can choose whether certain conditions apply to them.

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**Carrier Specific Health Conditions**

Please answer the following carrier specific health questions to the best of your knowledge and provide any required additional details.

|                                    |                                                                                                                                                       |
|------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="button" value="No"/>  | Currently taking prescribed medication(s) for a condition not otherwise listed?                                                                       |
| <input type="button" value="Yes"/> | Do you have any current or previous insurance coverage (health, dental, life, etc) other than what has been provided to you by your current employer? |
| <input type="button" value="Yes"/> | Are you or your spouse covered by Medicare?                                                                                                           |
| <input type="button" value="No"/>  | Has any named person incurred medical expenses or claims exceeding \$10,000 in the past 24 months?                                                    |
| <input type="button" value="No"/>  | Used tobacco products in the last 12 months?                                                                                                          |
| <input type="button" value="No"/>  | Ever been convicted of a DWI/DUI or any other alcohol or controlled substance related incident?                                                       |
| <input type="button" value="No"/>  | Currently receiving disability for worker's compensation or payments from an auto carrier for an injury?                                              |

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The Employee can provide details about their conditions.

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### Health Condition Details

Please select your family member and the corresponding condition for which you answered "yes" in the previous section(s) and click on the "Go" button. To the best of your knowledge, please provide some details relating to that condition by filling out the following required fields and then click the "Add Condition" button. If you selected "Yes" to medications, you will have to provide details about that medication on the next page.

To add each new condition, select the family member and condition in the dropdown menus and complete the required fields with an asterisk and then click on the "Add Condition" button. When you are finished adding conditions, you can click on the continue button. Enter 'NA' if field does not apply. You may include any additional information at the end of the application process on the Review Page in the text box provided.

To remove a condition, simply check the box in the right panel beside a name and click "Remove". To update a condition you can click on the desired name.

Previous Continue

| Name                       | Condition                    | Select                   |
|----------------------------|------------------------------|--------------------------|
| <a href="#">john.doe</a>   | Currently Disabled           | <input type="checkbox"/> |
| <a href="#">john.doe</a>   | Ankle/leg Sprain/Dislocation | <input type="checkbox"/> |
| <a href="#">mark.patel</a> | Skin Allergy                 | <input type="checkbox"/> |

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Family Member: john.doe Condition: Skin Allergy Go

#### Details for: john.doe - Skin Allergy

Condition/Diagnosis/Treatment Details:

Taking medications associated to this condition?

Ongoing/Chronic Condition:

Last Treated Date:  Physician Name:

First Treated Date:  Address:

Ongoing  City:  State:  Zip:

Treatments?

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The Employee can provide details about their medications if any taken.

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### Medication Information

When you click on the "Add Medication" button, you will be taken to the "Add Medication" page. In this page, you will be asked to fill out the following required fields and then click the "Add Medication" button. To add each new medication, select the family member and condition in the dropdown menus, required fields with an asterisk and click on the "Add Medication" button. When you are finished adding medications, you can click on the "Continue" button. Enter "N/A" if field does not apply. To remove a medication simply click on the "X" in the right hand panel below the name and click "Remove Medication" you can click on the desired name.

Previous      Continue

| Name       | Medication | Set                      |
|------------|------------|--------------------------|
| john doe   | sfg        | <input type="checkbox"/> |
| mark patel | dfg        | <input type="checkbox"/> |

Family Member:       Condition:

Medication:       Reason:

Still Prescribed:       Date Last:       Date First:

Dosage:       Amount Per Day:       Refills:      

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If you selected medicare, you are required to fill in details.

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**Medicare**

Enter the medicare information for you and/or your spouse. Once the medicare information is added click Continue to continue the application.

Please attach copies of all Medicare Cards when you send your application(s).

Previous
Continue

**Self**

Reason ▼

Age

|                                     |                |          |  |
|-------------------------------------|----------------|----------|--|
| Part A                              | Effective Date | End Date |  |
| <input checked="" type="checkbox"/> | 1/1/2000fe     | inf      |  |
| Part B                              | Effective Date | End Date |  |
| <input type="checkbox"/>            |                |          |  |
| Part C                              | Effective Date | End Date |  |
| <input checked="" type="checkbox"/> | 1/1/2000       | 1/1/2000 |  |
| Part D                              | Effective Date | End Date |  |
| <input type="checkbox"/>            |                |          |  |

**Spouse**

Reason ▼

|                          |                |          |  |
|--------------------------|----------------|----------|--|
| Part A                   | Effective Date | End Date |  |
| <input type="checkbox"/> |                |          |  |
| Part B                   | Effective Date | End Date |  |
| <input type="checkbox"/> |                |          |  |
| Part C                   | Effective Date | End Date |  |
| <input type="checkbox"/> |                |          |  |
| Part D                   | Effective Date | End Date |  |
| <input type="checkbox"/> |                |          |  |

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Continue

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The employee is asked to review all information. They can access and edit any part of the application from this page.

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**Review**

Please review your information. If you find an errors or omissions you can return to the appropriate part of the application to correct the information.

**Employee Information**  
[Click here to edit](#)

| Employee Name | SSN       | Date of Birth | Hire Date | Marital Status |
|---------------|-----------|---------------|-----------|----------------|
| john doe      | 125654587 | 10/14/83      | 10/13/06  | Married        |

**Dependent Information**  
[Click here to edit](#)

| Dependent Name | SSN       | Birth Date | Relation   |
|----------------|-----------|------------|------------|
| mark patel     | 125653214 | 01/01/00   | Child      |
| jack rusel     | 548789652 | 04/05/85   | Child      |
| james patel    | 154587896 | 01/01/06   | Grandchild |
| sarh patel     | 125458965 | 01/01/85   | Spouse     |
| greg patel     | 232568956 | 01/01/05   | Stepchild  |
| julie patel    | 123654879 | 01/01/00   | Child      |

**Enrollment Status**  
[Click here to edit](#)

| Type of Coverage | Status for Myself | Status for My Spouse          | Status for My Dependents                                |
|------------------|-------------------|-------------------------------|---------------------------------------------------------|
| Medical          | Enrolled          | Enrolled                      | Enrolled                                                |
| Dental           | Enrolled          | Enrolled                      | Waiving coverage because Cost                           |
| Vision           | Enrolled          | Waiving coverage because Cost | Waiving coverage because Choose to be without insurance |

**Current or Previous Coverage**  
[Click here to edit](#)

| Family Member | Policy Number |
|---------------|---------------|
| john doe      | 4112599       |

**Medicare Information**  
[Click here to edit](#)

| Family Member | Part A | Effective Date | Part B | Effective Date | Part C | Effective Date | Part D | Effective Date |
|---------------|--------|----------------|--------|----------------|--------|----------------|--------|----------------|
| Myself        | Yes    | 1/1/2000fc     |        |                | Yes    | 1/1/2000       |        |                |

**Medical Information**  
[Click here to edit](#)

| Family Member | Medical Conditions                           | Medications |
|---------------|----------------------------------------------|-------------|
| Myself        | Ankylosing Spondylitis<br>Currently Disabled | sfg         |
| mark patel    | Skin Allergy<br>Currently Disabled           | dfg         |

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You can print out the application from this page.

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### Print Applications

**IMPORTANT - PLEASE READ CAREFULLY BEFORE SUBMITTING THE ENROLLMENT FORMS**

Step 1: You will need to have Adobe Acrobat Reader 6.0 installed on your computer to use the "Printable Version" of the insurance applications. If you do not have this program, click on the "Get Acrobat Reader" icon below and follow the directions on how to download this program for free. Once you have downloaded the program, you will have to open it to install. You will then be able to view and print your application(s). If you do not need Adobe Acrobat, continue to Step 2.



Step 2: Please review the application(s) to make certain that they are completed thoroughly. If an application is incomplete, the processing of your application(s) may be delayed.

Step 3: You may print the application(s) for your records. By clicking on a link below, Adobe Acrobat will open. You can print the application(s) from Adobe by clicking Print on the file menu.



Step 4: Send the printed applications as you have been instructed by your employer or broker.

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Instant Enrollment Application

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port Census

- Select
- 
- 
- 
- 
- 
- 
- Remove

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From the Employee Manager, only a broker has permission to print employee applications (click "print" below to view a sample application), but an employer can still edit employee records, upload a census, and reset passwords.

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Add Employee

Search:

Census:    example Ex

Employer: ABC Company

|                                                                      | First Name | Last Name | User ID    | Email                                                              | Status |
|----------------------------------------------------------------------|------------|-----------|------------|--------------------------------------------------------------------|--------|
| <a href="#">Edit</a>   <a href="#">Print</a>   <a href="#">Reset</a> | David      | George    | DGeor1235  | <a href="mailto:j.george@someplace.com">j.george@someplace.com</a> | Active |
| <a href="#">Edit</a>   <a href="#">Reset</a>                         | Angela     | Harris    | AHarris445 |                                                                    | Active |
| <a href="#">Edit</a>   <a href="#">Print</a>   <a href="#">Reset</a> | Joe        | Dawson    | JDaws9984  |                                                                    | Active |
| <a href="#">Edit</a>   <a href="#">Print</a>   <a href="#">Reset</a> | Greg       | Myers     | GMyer5420  | <a href="mailto:gmyer@other.com">gmyer@other.com</a>               | Active |
| <a href="#">Edit</a>   <a href="#">Print</a>   <a href="#">Reset</a> | Dan        | Swanson   | DSwan4781  | <a href="mailto:dan_swanson@email.com">dan_swanson@email.com</a>   | Active |
| <a href="#">Edit</a>   <a href="#">Print</a>   <a href="#">Reset</a> | Anna       | Davis     | ADavi8455  | <a href="mailto:annad@internet.net">annad@internet.net</a>         | Active |

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From the Employer Manager, a broker can reset an employer's password, access employer and employee information, or batch print group applications.

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Search:

|                       | Status | Employees                | Employer Name                              | User ID      | Broker Contact | Count | Application Status          | Labels               | Select                                |
|-----------------------|--------|--------------------------|--------------------------------------------|--------------|----------------|-------|-----------------------------|----------------------|---------------------------------------|
| <a href="#">Reset</a> | Active | <a href="#">Add/Edit</a> | <a href="#">Acme Warehouse</a>             | AJohnson123  | Anderson, Jake | 54    | <a href="#">20 Complete</a> | <a href="#">View</a> | <input type="checkbox"/>              |
| <a href="#">Reset</a> | Active | <a href="#">Add/Edit</a> | <a href="#">Bank of Trust</a>              | KBreen64751  | Brown, Joe     | 40    | 0 Complete                  | <a href="#">View</a> | <input type="checkbox"/>              |
| <a href="#">Reset</a> | Active | <a href="#">Add/Edit</a> | <a href="#">Coffee House International</a> | LVand20120   | Brown, Joe     | 12    | <a href="#">10 Complete</a> | <a href="#">View</a> | <input type="checkbox"/>              |
| <a href="#">Reset</a> | Active | <a href="#">Add/Edit</a> | <a href="#">Midwest, Inc.</a>              | GHalvers8945 | Smith, Paul    | 22    | <a href="#">22 Complete</a> | <a href="#">View</a> | <input type="checkbox"/>              |
|                       |        |                          |                                            |              |                |       |                             |                      | <input type="button" value="Remove"/> |

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