# IDAHO
# GROUP INSURANCE
# EMPLOYEE ENROLLMENT FORM

**TIME INSURANCE COMPANY**

*HOME OFFICE USE ONLY* Group # _____ Certificate # _____

**Instructions for completing this enrollment form**

1) Each eligible employee enrolling for any coverage offered must complete the entire enrollment form. If enrolling on an existing group or making changes to existing coverage, you must also complete **Section D**.
2) Any eligible employee waiving coverages offered will need to complete **Sections A, B, G and I**.
3) This enrollment form must be completed in ink. White-out is not allowed and any alterations must be initialed.
4) If your employer offers multiple medical plans, please review the options with your employer.

Name of Employer: _____

Your Work Address: _____

## SECTION A – EMPLOYEE INFORMATION

Employee's Name: _____ (*Last* / *First* / *MI*)

Employee's 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: _____ 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 *(Month/Day/Year)*: ____ / ____ / ____

## SECTION B – COVERAGE REQUESTED (Medical history and details sections required for Medical, Life, Disability coverages only.)

**If waiving coverage for yourself, and/or your dependents, please fully complete the **Waiver of Coverage** in **SECTION G** of this enrollment form.*

**MEDICAL:** ☐ None* ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee, Spouse & Children

**DENTAL:** ☐ None* ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee, Spouse & Children

**SHORT TERM DISABILITY:** Amount $_____/weekly

**LIFE / AD&D AMOUNT:** $ _____ *(If no Beneficiary is designated, benefits will be paid according to the terms of the Certificate of Insurance or to your estate.)*

Name of Beneficiary: _____ Relationship to Employee: _____

## SECTION C – PERSON(S) TO BE COVERED

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

| Last Name | First Name | Relationship & Gender | Date of Birth (Mo/Day/Yr) | State of Birth | Social Security Number | Full-Time Student (age 19+) |
|---|---|---|---|---|---|---|
| | | Employee ☐ M ☐ F | / / | | – – | |
| | | Spouse ☐ M ☐ F | / / | | – – | |
| | | Child ☐ M ☐ F | / / | | – – | ☐ Yes ☐ No |
| | | Child ☐ M ☐ F | / / | | – – | ☐ Yes ☐ No |
| | | Child ☐ M ☐ F | / / | | – – | ☐ Yes ☐ No |

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. _____

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

Your Employer's Main Location Address: _____ Employer Phone # _____

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

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

Requested Effective Date: ____ / ____ / ____

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

If your employer has multiple medical plans, indicate which plan you are requesting.** Medical Plan #: _____

***Please contact your employer for the plan options/descriptions which are identified on your employer's billing statement and/or quote.*

## SECTION E – MEDICAL HISTORY

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

### PRESCRIPTION DRUG INFORMATION

1. Have you or any of your dependents included on this enrollment form been prescribed medication in the past 18 months? ☐ Yes ☐ No
   If "Yes," list below. (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 |
|---|---|---|---|---|---|
| | | | | | |
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**For all "YES" answers to the following questions, provide full details in SECTION F on next page.**

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; Lung/Respiratory 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, Been Counseled or Been Treated for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), or Sexually Transmitted Diseases?
3. Have you or any of your dependents included on this enrollment form within the past *5 years* 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 *5 years*, 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 two 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 Workman's 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. Are you or any of your dependents included on this enrollment form being treated for the following conditions?
   a. Hypertension/High Blood Pressure ..... ☐ Yes ☐ No
      If "Yes," list last 3 blood pressure readings: 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, Behavioral or Eating 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 F -- 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 (From/To) | Explain Treatment Include any Hospitalization, Tests or Surgery | Results/Degree of Recovery and Current Status | Physician/ Specialty/ Hospital Telephone Number |
|---|---|---|---|---|---|---|
| | | | | | | |

## SECTION G – WAIVER OF COVERAGE

I understand that I am eligible to apply for coverage through my employer.

I **DO NOT** want coverage for the following: *(Check all that apply)*

| Persons Waiving | Coverage Waived | Reason for Waiving | Carrier Information |
|---|---|---|---|
| ☐ **Primary Insured** | ☐ Medical<br>☐ Dental | ☐ Coverage under spouse's group plan<br>☐ Individual medical plan | Carrier Name(s): _____<br>_____ |
| ☐ **Spouse** | ☐ Medical<br>☐ Dental | ☐ Medicare/Medicaid<br>☐ Other | Policy Number(s):<br>_____ |
| ☐ **All Children** | ☐ Medical<br>☐ Dental | _____<br>_____ | _____<br>_____ |
| ☐ **Specific Child/Children** | ☐ Medical<br>☐ Dental | _____ | _____<br>OR Provide a copy of the ID card |

## SECTION H – PRIOR INSURANCE COVERAGE INFORMATION

***(Failure to supply complete information may result in a pre-existing condition limitation.)***

1. Have you and all dependents you are enrolling been covered by this employer's major medical plan(s) for the past 12 months?..... ☐ Yes ☐ No
2. Have you, your spouse or dependent children been covered by any type of medical plan within the last 18 months?..... ☐ Yes ☐ No
   If "Yes," list all plans in effect during the past 18 months below.
3. Have you, your spouse or dependent children been covered by a dental plan within the last 12 months? ..... ☐ Yes ☐ No
   If "Yes," was orthodontic treatment included? ..... ☐ Yes ☐ No

| Covered Persons | Insurance Company Name and Policy # | Effective Date | Termination Date | Reason for Termination |
|---|---|---|---|---|
| ☐ Employee<br>☐ Spouse<br>☐ Child | | | | |
| ☐ Employee<br>☐ Spouse<br>☐ Child | | | | |

Will any current medical plan remain active if coverage is approved? ☐ Yes ☐ No If "Yes," for whom? _____

## SECTION I – AUTHORIZATION AND SIGNATURE

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 Time Insurance Company to determine eligibility for insurance for myself and persons listed on this enrollment form as my spouse and/or dependent children.

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

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 certificate of insurance; (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 not eligible, 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 insurability 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 Time Insurance Company.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, pharmacy or pharmacy-related facility, the Medical Information Bureau, consumer reporting agency, insurance or reinsurance company or employer, having information about me and/or my dependents to provide all such information as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company 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 Time Insurance Company, 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 Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations.

Information regarding your insurability will be treated as confidential. Time Insurance Company, 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 for the Bureau's information office is Post Office, Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

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 Time Insurance Company to make eligibility or enrollment determinations relating to me and/or my dependents or for Time Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Assurant Health, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization. I understand that Assurant Health markets products underwritten and issued by Time Insurance Company and that all references to Time Insurance Company in this authorization also includes Assurant Health.

This authorization expires upon the earliest of the following events: denial of my application, declination of enrollment, or, if insured, when I am no longer an insured of Time Insurance Company, 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 insurance 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 Time Insurance Company. The agent has no right to bind coverage, to alter the terms of insurance 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 Proposed Insured** _____ **Date** _____

**PLEASE NOTE: 1) Time Insurance Company 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.**

**Read the Important Information Section on the following page.**

## Important Information for Applicant and Eligible Dependents regarding the Preexisting Condition Exclusion and Initial Notice About Special Enrollment Rights

**Preexisting Condition Exclusion**

This plan imposes a "preexisting condition exclusion." This means that if you have a medical condition before coming to our plan, you may have to wait a certain period of time before the plan 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. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 60 days after birth, adoption or placement for adoption.

This exclusion may last up to 12 months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, the length of this exclusion period is reduced by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the length of the preexisting condition exclusion if you have not experienced a break in coverage of 63 days or more. To reduce the 12-month exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage. Please contact us with any questions about preexisting condition exclusion and creditable coverage.

**Notice of Special Enrollment**

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). However, you must 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. However, you must request enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, please contact our Customer Service Department at 800-743-8463.