BRM SPECIALTY MARKETS

EMPLOYEE SELF-FUNDED HEALTH PLAN ENROLLMENT CARD

SECTION 1 – EMPLOYEE INFORMATION

FULL NAME OF EMPLOYEE					MARITAL STATUS	**ADM. USE ONLY**
RESIDENCE ADDRESS	CITY		STATE		ZIP	CASE NO.
TELEPHONE NUMBER (include area code)	Best time to contact (if additional information is required by administrator)					EMPLOYEE NO.
DATE BEGAN FULL TIME (mm/dd/yy)	DOB (mm/dd/yy)	HEIGHT	WEIGHT	SOCIAL SECURITY NUMBER		CLASS
EMPLOYED BY	EMPLOYER'S PHONE (include area code)		AVG. NO. HOURS WORKED WEEKLY			EFFECTIVE DATE
EMPLOYER'S LOCATION – STREET ADDRESS	CITY		STATE	ZIP		OCC YES ❑ NO ❑
OCCUPATION AND DUTIES						UWF 48 YES ❑ NO ❑ DATE _____
❑ I AM ❑ I AM NOT AN OWNER, PARTNER OR CORPORATE OFFICER						UWF 40 YES ❑ NO ❑
I Am Enrolling for (check one): ❑ SELF ONLY ❑ SELF AND SPOUSE ❑ SELF AND CHILD(REN) ❑ SELF, SPOUSE & CHILD(REN)						HEALTH YES ❑ NO ❑

EMPLOYEE WAIVER ❑

I AM NOT ENROLLING BECAUSE: ❑ Covered by another group/individual health plan. ❑ Other (explain) _____

DEPENDENT WAIVER

If you have dependents (spouse and/or children) and are not enrolling **all** of them, please complete the following:

I AM NOT ENROLLING MY (check one or both): ❑ **SPOUSE** ❑ **CHILD(REN)** (check one)
BECAUSE: ❑ Covered by another group/individual health plan. ❑ Other (explain) _____

I understand I have the right to enroll my dependents at this time. I am voluntarily declining to enroll my dependents and have not been induced or pressured by anyone to decline such coverage. I understand that, if I do not enroll my dependents at this time, and they do not have other qualifying coverage, their right to enroll in the future may be restricted, with a delayed effective date or an extended Pre-Existing Condition Limitation Period.

PARTICIPANT INFORMATION **Complete for each person to be enrolled (use additional sheet if necessary).**

NAMES OF PARTICIPANTS	RELATIONSHIP	SEX	HEIGHT	WEIGHT	DATE OF BIRTH	SOCIAL SECURITY NUMBER	ADM. USE ONLY MUW	MHX	LAT	D&R	PXT
1. Employee Name	Self										
2.											
3.											
4.											
5.											

May be photocopied or duplicated for use. Please complete in ink and initial any alterations

Complete information on all pages in ink. Sign and date last page.

SECTION 2 – PRIOR COVERAGE CREDIT

Have you or your dependents been covered under any health benefit plan within the last 90 days? ..... ❑ YES ❑ NO

If Yes, to establish prior coverage credit, please provide the following information on all coverage in force in the past 12 months (most of this information can be obtained from your current benefit plan Identification Card):

Coverage Type ❑ Comprehensive Major Medical ❑ Other (please provide copy of the benefit plan or schedule of benefits)

Name of Health Plan _____ Health Plan Phone Number (_____)

Effective Date of Prior Coverage _____

Termination Date: _____ Reason for Coverage Termination _____

Plan Type ❑ Employer Sponsored Employer Name _____ Policy/Cert. Number _____

❑ Individual Policy/Certificate Number _____

Coverage was for (check all that apply): ❑ Self ❑ Spouse ❑ Children

Proof of coverage is required if prior coverage is other than your current employer's plan. Please provide us with a copy of your Certificate of Creditable Coverage provided by the health plan or other suitable documentation. If coverage for self or a dependent is from a different source please document on a separate sheet of paper and attach.

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SECTION 3 – MEDICAL INFORMATION

1. In the past 5 years, have you or anyone enrolling for coverage had a diagnosis of or consultation, treatment or medication for:

	YES	NO		YES	NO
Brain or Nervous System	☐	☐	Diabetes or Sugar in Urine	☐	☐
Endocrine or Adrenal Disorder	☐	☐	Digestive or Gastrointestinal Disorder	☐	☐
Liver, Pancreas or Kidney	☐	☐	Breast or Reproductive Organs	☐	☐
Abnormal Blood Pressure	☐	☐	Autoimmune Disorders	☐	☐
Heart or Circulatory System	☐	☐	Disorders of Back or Spine	☐	☐
Chest Pain or Stroke	☐	☐	Rheumatoid Arthritis	☐	☐
Blood Disorder	☐	☐	Emphysema, Tuberculosis, Chronic Obstructive Pulmonary Disease	☐	☐
Lymphatic Vessels or Glands	☐	☐			
Cirrhosis or Hepatitis	☐	☐	Multiple Sclerosis or Cystic Fibrosis	☐	☐
Leukemia or Hodgkin's Disease	☐	☐	Skin or Collagen Disease	☐	☐
Cancer (excluding Basal Cell Carcinoma)	☐	☐	Disease of the Muscles	☐	☐

Please provide details for any "Yes" answer below

2. Within the last 5 years, has anyone enrolling for coverage been diagnosed as having or been treated for human immunodeficiency virus (HIV) infection, any other acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC) condition, significant weight loss, chronic fatigue, diarrhea, night sweats or enlarged glands? ..... ❑ YES ❑ NO

3. Are you or any dependent (whether enrolling for coverage or not) currently pregnant or anticipating surgery, or is anyone enrolling for coverage disabled, restricted or unable to perform the normal activities of daily living and self care? ..... ❑ YES ❑ NO

4. During the past 5 years, has anyone enrolling for coverage visited a doctor, had a medical consultation, had surgery, or been hospitalized? ..... ❑ YES ❑ NO

5. Are you or any dependent enrolling for coverage currently taking medication? ..... ❑ YES ❑ NO

6. For anyone enrolling for coverage, is there any existing medical condition or problem (including any undiagnosed symptoms) that has not otherwise been disclosed on this enrollment form? If "yes" answer, provide details below. ..... ❑ YES ❑ NO

Complete information on all pages in ink. Sign and date last page.

Use this space to give details to any “YES” answer to questions 1 through 6. Use a separate sheet if additional space is needed; sign & attach additional pages. If taking medication for high blood pressure, please include your last 3 blood pressure readings.

Person	Medical Condition or Specific Reason for Treatment	Dates of Treatment	Medications & Dosages	Recovery Status	Please list any treatment, surgery or anticipated surgery for this condition.

Complete information on all pages in ink. Sign and date last page.

SECTION 4 – EMPLOYEE STATEMENT AND SIGNATURE

I HEREBY: Request enrollment in the self-funded Group Health Plan (Plan) established and maintained by my employer (Employer) for its eligible employees and their eligible dependents; Represent that I am an eligible employee of the Employer; Represent that my statements and answers to the questions in this enrollment form are true and complete to the best of my knowledge and belief; and Authorize the Employer to deduct any required Plan contribution from my earnings.

I FURTHER ACKNOWLEDGE AND UNDERSTAND: My statements and answers in this enrollment form will be the basis for approving Plan coverage and any material misrepresentation or omission may result in an increase in Plan contribution rates or termination of my coverage; Any person who, knowingly and with intent to defraud, submits an enrollment form, or files a claim, containing a materially false statement, or omitting materially false information, may be found guilty of fraud in a court of law.

SPECIAL ENROLLMENT RIGHTS: If you acquire a new dependent by marriage, birth, adoption or placement for adoption, he/she may be able to enroll without delay or penalty, if you request enrollment within 31 days (of the marriage, birth, adoption or placement for adoption); If you decline enrollment for any dependent (including your spouse) because of other health plan or group insurance coverage, and that dependent subsequently becomes ineligible for the other coverage (or the employer stops contributing towards that coverage), he/she may be able to enroll without delay or penalty, if you request enrollment within 31 days of ineligibility or termination of employer contributions; If you decline enrollment for any dependent (including your spouse) because of coverage under Medicaid or a State child health plan, and that dependent's coverage is subsequently terminated due to ineligibility, he/she may be able to enroll without delay or penalty, if you request enrollment within 60 days of the termination of coverage; If you decline enrollment for any dependent (including your spouse) and that dependent subsequently becomes eligible for a premium assistance subsidy from Medicaid or a State child health plan, he/she may be able to enroll without delay or penalty, if you request enrollment within 60 days of eligibility for the subsidy. To request special enrollment contact the Employer.

PERSONAL INFORMATION NOTICE: As required by law, this notice is intended to inform you that 1) Personal information may be collected from third parties; 2) Such information as well as other personal or privileged information collected by the health plan or its legal representative may be in certain instances, as prescribed by law, disclosed to other third parties without your prior authorization; 3) You have the right to access and correct the collected information; 4) Your right to access does not include any information which relates to and is collected in connection with, or in reasonable anticipation of, a claim or civil or criminal proceeding; 5) We will provide a more detailed notice of information practices upon request.

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize the disclosure of all nonpublic personal information and individually identifiable protected health information for me (and my dependent(s), if applicable), including but not limited to employment status, other health plan coverage, diagnosis, prognosis, medical treatment or care, and physical or mental conditions (including alcohol or drug dependency), by any physician, medical practitioner, hospital, other medical related facility, insurance company, employer or benefit plan having such information, to the health plan or its legal representative, agent or vendor, for the purpose of processing enrollment and claims. I acknowledge and agree that this authorization shall be valid for two (2) years; that I may revoke it in writing at any time; that I may request a copy of this authorization; that enrollment, but not the processing of claims, is conditioned on my signing this authorization; that this authorization will be used as its own document, separate from the enrollment form; that a photocopy of this authorization shall be as valid as the original; that any documentation or information disclosed pursuant to this authorization may be re-disclosed and may no longer be covered by federal or state privacy laws; and that I have authority to act as the personal representative of my dependent(s) (if requesting dependent coverage).

Signature of Employee X _____ Date _____

Electronic copies of this enrollment card submitted via facsimile, email, or other electronic means shall be deemed an original.
RETURN ENROLLMENT CARD TO BRM Specialty