EMPLOYEE ENROLLMENT FORM

APPLICATION IS BEING MADE FOR:

	MEDICAL	DENTAL	VISION	LIFE	STD
EMPLOYEE COVERAGE:	☐	☐	☐	☐	☐
SPOUSE COVERAGE:	☐	☐	☐	☐	N/A
CHILD(REN) COVERAGE:	☐	☐	☐	☐	N/A

EMPLOYEE NAME – LAST, FIRST, MIDDLE INITIAL	DATE OF BIRTH / /	☐ MALE ☐FEMALE	SOCIAL SECURITY NUMBER - -	
HOME ADDRESS	CITY	STATE	ZIP	PHONE NUMBER ( ) -

HEIGHT: __________ Ft. __________ In. WEIGHT ______________

MARITAL STATUS ☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ SEPARATED DATE: _________________	MINIMUM HOURS WORKED PER WEEK	JOB TITLE:
NAME OF EMPLOYER:	DIVISION	DATE OF FULL TIME EMPLOYMENT
IS ANY FAMILY MEMBER COVERED BY ANOTHER MEDICAL PLAN? ☐ YES ☐ NO OR BY MEDICARE? ☐ YES ☐ NO	IF YES, ☐ SINGLE COVERAGE ☐ FAMILY COVERAGE	NAME, ADDRESS, PHONE NUMBER OF COMPANY

PLEASE PRINT NAMES OF DEPENDENTS APPLYING FOR COVERAGE	SOCIAL SECURITY NUMBER	RELATIONSHIP TO APPLICANT	DATE OF BIRTH	GENDER	HEIGHT & WEIGHT
		SPOUSE			______ Ft. _____ In. Weight ________
					______ Ft. _____ In. Weight ________
					______ Ft. _____ In. Weight ________
					______ Ft. _____ In. Weight ________

Group Life Insurance: (Amounts in excess of $25,000 require pre-approval)

Employee: ☐ Smoker ☐ Non-Smoker **Amount:** ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ Other

Employee Beneficiary: ____

Name Relationship Contingent

Spouse: ☐ Smoker ☐ Non-Smoker **Amount:** ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ Other

Spouse Beneficiary: ____

Name Relationship Contingent

Dependent(s): ☐ None ☐ One Unit ($3,000) ☐ Two Units ($6,000)

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, government agency, insurance company, the Medical Information Bureau, or other organization or person that has any records or knowledge of me or any family member for whom coverage is requested, to give WMI TPA or my health plan administrator any such information. A photographic copy of this authorization shall be valid as the original. I declare that to the best of my knowledge and belief, the information given on this application, including the Health Information on the back side of this application, if applicable, is correctly recorded, true and complete. If I subsequently become aware of information different from that provided on this application, I agree to provide that additional information promptly to WMI TPA.

Signature:_______________________________________ **Date:**______________________________

Please sign your name – DO NOT PRINT OR TYPE

FOR OFFICE USE ONLY

Effective Date: ____________________________ VGL Amount: ________________________ ☐ Original Group ☐ Special Enrollee

Termination Date: __________________________ Disability Income Amount: _____________ ☐ New Enrollee

Class Change Date: _________________________

EMPLOYEE NAME:	SOCIAL SECURITY NUMBER:

EVIDENCE OF HEALTH - This section does not need to be completed if you are a new employee of an already existing client.

Have you or any of your dependents been treated for or had symptoms of immune system or blood disorder, cancer, tumor, diabetes, stroke, heart attack, heart disease or disorder? ☐ YES ☐ NO

Are you or any of your dependents partially or totally disabled or handicapped? ☐ YES ☐ NO

Have you or any of your dependents been treated for, or had symptoms of, any medical condition that may require surgical correction or hospitalization in the future? ☐ YES ☐ NO

Have you or any of your dependents ever had, been treated for or been told you have abnormal blood pressure or other circulatory disorders, disorders of the nervous system, epilepsy, alcoholism, mental or emotional disorders, arthritis, bone, joint or back disorders, hernia, disorders of the stomach, intestines or rectum, liver disorders, lung or respiratory disorder, eye or ear disorder, disorder of the urinary tract, kidneys or reproductive system? ☐ YES ☐ NO

Have you or any of your dependents had any mental or physical disorders, examination, hospitalization, treatment, medical advice or surgery not mentioned above? ☐ YES ☐ NO

Have you or any of your dependents taken prescription medication within the past 24 months? ☐ YES ☐ NO

List full details to any questions you have answered "yes". Attach additional sheets if necessary.

NAME	AGE	NATURE OF AILMENT OR ILLNESS, OR NAME OF MEDICATION	DURATION AND DATES OF TREATMENT	DATE OF FULL RECOVERY	NAME AND ADDRESS OF DOCTORS AND HOSPITALS

WAIVER OF GROUP COVERAGE

MUST BE COMPLETED IF COVERAGE IS DECLINED OR REFUSED BY AN ELIGIBLE EMPLOYEE

IMPORTANT! If you are waiving your right to coverage under this plan, you must declare the reason for declination in writing below. Failure to declare your reasons for waiving coverage may limit your opportunity to join the plan later and could result in denial of claims for preexisting conditions.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if employer contributions towards your or your dependent's other coverage terminate), provided that you request enrollment within 31 days after your other coverage ends. 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, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. To request such special enrollment, please contact Kay Harrison, Enrollment Department, WMI TPA, (801) 263-8000 x104 or (800) 748-5340 x104.

I have been given the opportunity to participate in the benefit plan, but after due consideration, I have elected not to participate in each of the categories checked below:

APPLICATION IS WAIVED FOR:	MEDICAL	DENTAL	VISION	STD
EMPLOYEE COVERAGE:	☐	☐	☐	☐
SPOUSE COVERAGE:	☐	☐	☐	N/A
CHILD(REN) COVERAGE:	☐	☐	☐	N/A

REASON FOR REFUSAL OF MEDICAL COVERAGE:

☐ Have coverage under another plan. Name of other Plan:____

Indicate who is covered under other plan(s): ☐ SELF ☐ SPOUSE ☐ CHILD(REN)

☐ Other. Give Explanation:____

Signature: ______________________________________ Date: ______________________

Please sign your name - DO NOT PRINT OR TYPE