



# YCBA 21+



## Group Enrollment Form

Employer \_\_\_\_\_

Employee \_\_\_\_\_ SS# \_\_\_\_\_ Birthdate \_\_\_\_\_

Address, City, State and Zip \_\_\_\_\_

Male  Female  Single  Married  Widowed  Divorced  Separated

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Date Employed Full-time \_\_\_\_\_

# of Hours Worked per week for Employer \_\_\_\_\_ Salary \_\_\_\_\_  Annual  Monthly  Biweekly  Weekly

Occupation of Duties \_\_\_\_\_

Do you want medical coverage for yourself?  Yes  No If "No" to either question, complete TO DECLINE

Do you want medical coverage for your dependents?  Yes  No COVERAGE Section below. If dependents are to be covered, list below.

Dependent Name	Sex	Birthdate	SS#	Relationship
Spouse				
Children				

Note: If age 19 or older, list only if a full-time student.

### MEDICAL QUESTION

Within the last 5 years, have you or any dependent been medically diagnosed/treated for any of the following chronic medical conditions (If "Yes" Please Circle): heart or lung condition; cancer; liver or kidney disease; diabetes; neuromuscular disorder, HIV, AIDS, Aids Related Complex (ARC); or are any of you now: pregnant; disabled, or have you been medically advised to undergo surgery or hospitalization?  Yes  No If "Yes" attach sheet stating date(s), attending physician(s) and treatment(s).

Name of patient: \_\_\_\_\_  
Date of first treatment: \_\_\_\_\_  
Date(s) of following treatment(s): \_\_\_\_\_  
Degree of recovery: \_\_\_\_\_  
Condition treated: \_\_\_\_\_  
Medication and dosage taken: \_\_\_\_\_  
Date - From: \_\_\_\_\_ Through \_\_\_\_\_

Name of patient: \_\_\_\_\_  
Date of first treatment: \_\_\_\_\_  
Date(s) of following treatment(s): \_\_\_\_\_  
Degree of recovery: \_\_\_\_\_  
Condition treated: \_\_\_\_\_  
Medication and dosage taken: \_\_\_\_\_  
Date - From: \_\_\_\_\_ Through \_\_\_\_\_

### COORDINATION OF BENEFITS

Are you or any of your dependents covered under another employer benefit plan?  Yes  No

If "Yes" - Who? \_\_\_\_\_ Date effective \_\_\_/\_\_\_/\_\_\_  
Insurance Carrier(s): \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_

### TOBACCO USAGE

Tobacco Usage - Has any proposed insured used any form of tobacco within the past 36 months?  Yes  No If "Yes", list name(s) below. I acknowledge that misrepresentation of this information may render the policy null and void.

X  
\_\_\_\_\_  
Employee's Signature Date

### TO DECLINE COVERAGE

By completing and signing below, you: 1) understand you are eligible for group health coverage and have had the plan explained; and, 2) waive all claim to benefits under the plan.  
You decline coverage for:  yourself  yourself and all dependents  dependents  spouse  
Reason -  HMO elected  covered by spouse's plan  premium cost  covered elsewhere  
If Covered elsewhere, name of insurance company \_\_\_\_\_

### TO ELECT COVERAGE

By signing below, you; 1) authorize any organization, institution or person that has any records or knowledge of you to give us or our representatives such information; 2) represent that the information given is complete and true to the best of your knowledge and belief; 3) acknowledge having read the Consumer privacy Notice; and, 4) agree a copy of this authorization is as valid as the original.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

## Consumer Privacy Notice

Information regarding your insurability will be treated as confidential. We or our reinsurers may, however, make a brief report to the Medical Information Bureau (MIB). The MIB is a non-profit membership organization of life insurance companies. It operates an information exchange on behalf of its members. If you apply to another MIB member company for: life or health coverage; or, a claim of benefits, the MIB, upon request will supply such company with the information it may have in its file.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction. This may be done by following the procedures set forth in the Federal Fair Credit Reporting Act.

The address of the MIB's information office is: P.O. Box 105, Essex Station, Boston, Massachusetts 02112. Their telephone number is (617) 426-3660.

We or our reinsurers may also release information in our files to other life insurance companies if you: apply for life or health insurance with them; or, file for a benefit claim.

Federal law required that notice of investigation be given to you if applying for insurance. By applying for insurance with us or our reinsurers, it is understood that an investigative consumer report may be prepared. Information is obtained through personal interviews with your neighbors, friends or others who know you. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional information about the nature and scope of this investigation.

## Notices

Any person who knowingly and willfully, for the purpose or attempt of procuring payments of any false or fraudulent claim or other benefit from an insurer: 1) makes or aids in making any false statement or representation or any material fact or thing, in: a) a written statement; b) the filing of a claim; c) the application or enrollment for coverage; or, 2) makes a written false representation as to the death or disability of an insured – commits the crime of insurance fraud. If you decline enrollment for yourself or a dependent because of other health coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided you request enrollment within 30 days after you 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 30 days after the marriage, birth, adoption, or placement for adoption.