Allstate BENEFITS

Employee Enrollment Form

EMPLOYER INFORMATION (must be completed)	
Company Name/DBA:	Company Address:

You must complete this form in its entirety in order for you or your dependents to be covered under the employer's group health plan. If you are waiving coverage for yourself or your dependents, it must be clearly indicated on this form. If you do not complete this form in its entirety for yourself or your dependents at least 5 business days prior to the effective date, you or your dependents may not be eligible for coverage until the next open enrollment period.

TO BE COMPLETED BY EMPLOYEE (if applying or waiving coverage)

BENEFIT PLAN:	GROUP NUMBER:

A - EMPLOYEE (Primary Applicant)

Legal Name: (Last)	(First)	(MI)

Social Security Number:	Gender: ☐ M ☐ F	Birth Date (mm/dd/yyyy):	**Average number of hours worked per week?**	**Date employed Full-Time: (mm/dd/yyyy)**

Home Street Address	City	State	Zip

Mailing Address (if different)	Mailing Address City	Mailing Address State	Mailing Address Zip

Home Phone:	Work Phone	Email Address:
Cell Phone:	Best Time to Call:	**Job Title**:

Status: ☐ Single ☐ Married Employee Status: ☐ W2 ☐ 1099 ☐ Owner/Partner	Check One: ☐ Full-Time ☐ Part-Time ☐ Retiree ☐ COBRA ☐ Cal-COBRA COBRA effective date(mm/dd/yyyy)	Earnings Basis: ☐ Salaried ☐ Hourly ☐ Commission

NEW ENROLLMENT or WAIVER, please check one:

☐ New Hire ☐ Qualifying Life Event:_____Date: (mm/dd/yyyy) _____
☐ Re-hire ☐ COBRA
☐ Open Enrollment ☐ Waiver of Coverage (complete section B)
☐ New Group ☐ Other: _____

B - WAIVER OF COVERAGE – DO NOT COMPLETE IF ENROLLING FOR COVERAGE

Complete and sign if waiving any or all coverages for self. All eligible employees must be listed as either enrolling or waiving coverage when first eligible.

Indicate the waiver reason below.

☐ Individual Medical ☐ Medicare/Medicaid ☐ COBRA/Continuation ☐ Tricare ☐ Spouse's/Parent Employer Plan
☐ Cost/Do not want (NO health coverage will exist) ☐ Other: _____

Neither I nor my dependents have been induced or pressured to decline coverage by my employer, the agent, or Allstate Benefits. My dependents and I have waived such coverage of our own accord.

Signature:	Date:

Printed Name:	Date employed Full-Time:

C – ONLY TO BE COMPLETED BY ADDITIONS TO EXISTING GROUPS OR FOR CHANGES TO EXISTING COVERAGE

Requested effective date: / / (Subject to Underwriting approval)

1. Groups with 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.*

2. If enrolling outside of your employer's open enrollment period, indicate the special enrollment reason (documentation may be required)

a) ☐ Marriage ☐ Birth ☐ Adoption ☐ Court ordered (copy of court order required)

For any event in a, list date of event ____/____/____

b) ☐ Divorce/Separation ☐ Involuntary loss of coverage, state reason for loss_____
☐ COBRA/Continuation exhausted ☐ Other _____

For any event in b, list coverage termination date ____/____/____

**Certificate of Creditable Coverage is required for all loss of coverage special enrollment events*

D – DENTAL OR DENTAL WITH VISION COVERAGE ELECTION

If your employer offers dental or dental with vision coverage, are you electing? ☐ Yes ☐ No

Check which of your family members will also enroll in dental or dental with vision coverage? ☐ Spouse ☐ Children

Groups with multiple dental plans, indicate which plan are you requesting.* Dental Plan #: _____

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

E – PERSONS TO BE COVERED

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

☐ Employee Only	☐ Employee Spouse	☐ Employee Child(ren)	☐ Family: Employee, Spouse, & Child(ren)

Include yourself & all family members to be insured **Last Name**	**First Name**	**Relationship & Gender**	**Date of Birth (MM/DD/YYYY)**	**Social Security Number**	**Medical election** (check if enrolling)	**Tobacco Use**
		Employee ☐ M ☐ F	XXXXXX	XXXXXXXXX	☐ Medical	☐ Yes ☐ No
		Spouse ☐ M ☐ F			☐ Medical	☐ Yes ☐ No
		Child ☐ M ☐ F			☐ Medical	
		Child ☐ M ☐ F				
		Child ☐ M ☐ F				
		Child ☐ M ☐ F				
		Child ☐ M ☐ F				

F – ADDITIONAL INSURANCE COVERAGE INFORMATION

1. Will any current medical plan remain active if coverage is approved?	☐ Yes ☐ No
a) If "Yes", for whom?	
b) Please provide carrier and ID/Group number	
2. Are you, your spouse or any dependent children currently covered under Medicare Part A, B, or D?	☐ Yes ☐ No
a) If "Yes", for whom?	
b) If yes, will coverage remain active if the coverage for which you are applying is approved?	☐ Yes ☐ No

G – MEDICAL HISTORY – Complete for all members enrolling in medical coverage					
	Height	Weight	Own a Motorcycle?	Convicted of a moving violation in the last year?	Convicted of a DUI/OWI in the last 5 years?
Employee			□ Yes □ No	□ Yes □ No	□ Yes □ No
Spouse			□ Yes □ No	□ Yes □ No	□ Yes □ No

Complete all questions below and check all that apply in Question 1. Complete Section H on the next page by providing complete details for each Yes answer and for all conditions checked in Question 1.

1. Have you or any of your dependents included on this enrollment form within the past *5 years* received treatment, testing, consulted with or received a diagnosis from a physician or provider for any of the following?.....☐ Yes ☐ No

☐ AIDS or HIV
☐ Alcohol or Drug Use, Abuse, or Dependency
☐ Arthritis or other Skeletal Disorder
  ☐ Osteoarthritis ☐ Rheumatoid
  ☐ Other
☐ Back Disorders
  ☐ Chiro ☐ Sprain/strain
  ☐ Surgery ☐ Other
☐ Blood Disorders (including anemia)
☐ Cancer or Tumor; Stage_____
  ☐ Local (confined to the organ where it began)
  ☐ Regional (spread to nearby lymph nodes/organs)
  ☐ Distant/Metastasis (spread to distant organs)
☐ Chest Pain
☐ Diabetes Mellitus Date of onset____/____/____
  ☐ Pre-Diabetes ☐ Diet Controlled
  ☐ Type I ☐ Type II
  ☐ Insulin Dependent ☐ Insulin Pump
☐ Diabetic Related Disorders
  ☐ Heart disease ☐ Nephropathy
  ☐ Neuropathy ☐ Peripheral Vascular Disease
  ☐ Retinopathy ☐ Stroke
☐ Digestive Disorders
  ☐ Crohn's Disease ☐ Ulcerative Colitis
  ☐ Other
☐ Ear/Eye/Nose/Throat Disorders
☐ Endocrine Disorders
☐ Fracture/Broken Bone
☐ Heart Disorders
  ☐ Angioplasty ☐ Bypass
  ☐ Heart Attack ☐ Other
☐ High Cholesterol
☐ High Blood Pressure
☐ Hodgkin's/Lymphoma/Leukemia
☐ Immune Disorders
☐ Infertility
☐ Kidney Disorders
☐ Knee Injury or Disorder
☐ Liver Disorder/Hepatitis
  ☐ Hepatitis B ☐ Hepatitis C
  ☐ Hepatitis D ☐ Other
☐ Lupus
  ☐ Discoid
  ☐ Systemic Lupus Erythematosus
☐ Mental, Nervous or Behavioral Disorder
  ☐ Inpatient Treatment ☐ Outpatient Treatment
  ☐ ADHD/ADD ☐ Anxiety
  ☐ Bipolar disorder ☐ Depression
  ☐ Other
☐ Migraine or Chronic Headache
☐ Multiple Sclerosis (MS)
☐ Muscle Disorders
☐ Nervous System Disorders
☐ Paralysis
☐ Partial or Total Disability
☐ Physical Disorder or Deformity
☐ Reproductive Disorders
☐ Respiratory/Lung Disorders
  ☐ Asthma ☐ Chronic Bronchitis
  ☐ COPD ☐ Other
☐ Seizures
☐ Sexually Transmitted Disease
☐ Stroke or Transient Ischemic Attack
☐ Thyroid Disorder
  ☐ Hyperthyroidism ☐ Hypothyroidism
  ☐ Growth Disorder ☐ Other
☐ Transplant
  ☐ Solid Organ ☐ Blood or Marrow
☐ Urinary Disorders
☐ Vascular Disorders

2. In the last 5 years, have you or any of your dependents included on this enrollment form:
   a. Been diagnosed with or treated for any condition(s) not identified above? .....☐ Yes ☐ No
   b. Been advised of the necessity or possibility of any future hospitalization, treatment, testing or surgery?...☐ Yes ☐ No

3. Are you or any of your dependents included on this enrollment form currently pregnant? .....☐ Yes ☐ No
   a. If yes, Indicate due date____/____/_____
   b. Is a Cesarean Section anticipated?.....☐ Yes ☐ No
   c. Are multiple births expected?.....☐ Yes ☐ No
   d. Are you/your dependent experiencing or anticipating any other complications?.....☐ Yes ☐ No

4. Have medications been prescribed in the past 18 months for you and/or any dependents included on this enrollment form. (Include pills, creams, injections, liquids, inhalers, pumps, etc.) .....☐ Yes ☐ No

H – DETAILS

Please provide FULL DETAILS to any yes/checked answers in section G; including the name of the Applicant(s), condition(s), treatment(s), medication(s), and dates. If more space is needed please attach a separate page with details; include the Employee's name.

Question	Person	Condition/Diagnosis	Dates Treated	Treatment including Medications and Dosage	Date Last Taken	Prognosis

I – *** NOTICE OF FEDERAL MANDATES ****** INITIAL NOTICE ABOUT SPECIAL ENROLLMENT RIGHTS*****

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).

You must, however, 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.

Effective April 1, 2009 a federal mandate took effect that allows for a Special Enrollment Period, which is outlined below.

A Special Enrollment Period will be provided for an employee and his/her dependent(s) who are eligible, but not enrolled, for coverage under the terms of the employer's plan to enroll for coverage if either of the following conditions are met:

a) The employee or dependent is covered under a Medicaid plan or under a State child health plan and coverage of the employee or dependent under that plan is terminated as a result of loss of eligibility for coverage. The request for coverage under the employer's group health plan must be submitted no later than 60 days following the date of termination of such prior coverage under Medicaid or a State child health plan.

b) The employee or dependent becomes eligible for assistance under a Medicaid plan or under a State child health plan. The request for coverage under the employer's group health plan must be submitted no later than 60 days following the date the employee or dependent is determined to be eligible for such assistance.

J – APPLICATION 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 The Association Benefits Solutions, LLC, marketed and hereinafter referred to as "Allstate Benefits" to determine eligibility for coverage under the Self-Funded Program ("Program") for myself and persons listed on this enrollment form as my spouse and/or dependent children.

I understand and acknowledge that I have elected to participate in the Section 125 plan offered by my employer, and I agree that my qualified insurance premiums may be paid by my employer through pre-tax salary/earnings reductions. I further acknowledge that my Social Security contribution and subsequent Social Security benefit will be slightly reduced.

I understand that (1) the answers given will be the basis of any coverage provided; (2) 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 coverage; (3) if coverage is not approved, I, my spouse and/or dependent children are not entitled to benefits; (4) if I, my spouse and/or dependent children waive coverage and decide to apply for coverage at a later date, evidence of eligibility may be required and benefits may be deferred for a specified period of time; and (5) coverage will not be effective until my employer receives notice that this enrollment form has been approved by Allstate Benefits.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, pharmacy or pharmacy-related entity, pharmacy benefits manager (PBM) or PBM-related entity, insurance or reinsurance company or employer, having information about me or my minor children to provide all such information as may be requested to Allstate Benefits, its legal representative or any medical records retrieval service Allstate Benefits may engage.

This authorization includes any and all information any of the foregoing 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 Allstate Benefits. 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 Allstate Benefits pursuant to this authorization will be protected by federal and state privacy laws and regulations.

I understand and agree that in connection with my application for coverage under the Program: (1) Allstate Benefits may obtain consumer reports which may include credit information, a driver history report, and/or personal or privileged information from third parties; (2) such information may be disclosed to affiliated or unaffiliated third parties without my prior permission but only as permitted or required by law; (3) upon my written request, Allstate Benefits will inform me if a consumer report was requested and the name and address of the consumer reporting agency that furnished the report; (4) I may also request access to and correction of information Allstate Benefits has collected on me; (5) Allstate Benefits may request and use subsequent consumer reports in updating and renewing any insurance or health coverage afforded in connection with this Application; and (6) Allstate Benefits will furnish a more detailed explanation of its information practices upon my request.

In connection with this application for health plan coverage, Allstate Benefits will review my credit report or obtain or use an insurance credit score based on the information contained in that credit report. Allstate Benefits may use a third party in connection with the development of my insurance credit score. I may request that my credit information be updated and if I question the accuracy of the credit information, Allstate Benefits will, upon my request, reevaluate me based on corrected credit information from a consumer reporting agency. I hereby authorize Allstate Benefits to obtain consumer reports on me.

I understand that this authorization is required in order to enable Allstate Benefits to make eligibility or enrollment determinations relating to me, my spouse and/or my dependents or for Allstate Benefits to make underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, or refuse to authorize Allstate Benefits to obtain a consumer report on me, Allstate Benefits may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying Allstate Benefits in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, National Health Insurance Company, 4455 LBJ Freeway, Ste 375, Dallas, TX 75244. Such revocation will not be valid to the extent Allstate Benefits has taken action in reliance on the authorization prior to its revocation. This authorization expires upon the earliest of the following: denial of my application, declination of enrollment, or when I am no longer covered under the Program, but in no event will this authorization be in effect for longer than 24 months from the date signed.

I acknowledge that knowing and willful misstatements in this enrollment form may constitute health care fraud, a criminal violation of 18 US Code Section 1347 (punishable by up to 10 years in prison).

Employee/Primary Applicant Signature:_____Date: _____