Employee Enrollment Application Form -

All Savers®

All Savers Alternate Funding

Please send correspondence to P.O. Box 19032, Green Bay, WI 54307-9032 • 1-800-291-2634

(Please fill out the entire enrollment application form to avoid processing delay. Please clearly print all information.)

Enrollee Social Security Number ___ – ___ – ____

Group No. 0 0 0 0 – 3 9 9 1 1 6

Enrollee Information

Employer Name HOLLERITH IT SOLUTIONS LLC		Employer Address (If more than one location)	
Last Name P A C H I M A T T A L A		First Name S I D D H A R T H A	Initial
❑ Single ❑ Married	Address	Apt# City State ZIP County	
Phone # ___ – ___ – ____		Gender ■ M ☐ F	Date of Birth 11/28/1991
Cell Phone # ___ – ___ – ____		Email Address SIDDHARTHGOUD28@GMAIL.COM	
Date Employed Full Time	Average Hours Worked Per Week	Occupation Are you an independent contractor? ☐ Yes ☐ No	

Enrollee and Dependent Information (Only for those applying).

If you need to list additional dependents, please use lined paper, sign and date it, and check this box: ☐

	Enrollee	Spouse	Child 1	Child 2	Child 3
First Name					
Middle Initial					
Last Name					
Gender	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F
Date of Birth					
Height					
Weight					
Social Security Number					
Primary Care Physician's Name					
Eligibility and Other Insurance (insurance that will be kept in addition to this coverage)					
Currently Working Full Time	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Plan to Keep Other Insurance Coverage	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Other Insurance Policy Number					
Name of Other Insurance Company(ies)					
Covered by Medicare/ Medicaid	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Medicare/Medicaid Coverage Effective Date					

Coverage and Change Request Information

Medical: ☐ Employee ☐ Family ☐ Employee/Spouse ☐ Employee/Dependent Child(ren)

Name of Medical Plan You Have Selected: _____

Change Request: ☐ Marriage ☐ Divorce ☐ Adoption ☐ Returning to School Full Time ☐ Court Order Date of Event: _____
(you may be required to provide proof of event)

Attach a written and signed statement by the employer for a requested coverage effective date other than employee effective date.
Effective date may not be guaranteed.

UnitedHealthcare®

Medical History

Please answer the following questions for yourself and each person listed on the Enrollee and Dependent Information Section on page one of this form. Please answer completely and truthfully. Has anyone on this enrollment application form been diagnosed, consulted with, or been examined or treated by any health care professional during the last 5 years for any illness, injury, or health condition in any of the categories listed below? If yes, please check the box that most appropriately describes the problem and explain fully below. Please note that, if you fraudulently leave out or fraudulently misrepresent information, we may terminate or not renew your coverage, or we may change your monthly payment retroactive to the date your coverage became effective. **All statements contained in this entire form must be true and correct and no material information can be withheld or omitted.**

1 Cancer/Tumor ☐ Yes ☐ No	☐ Breast ☐ Colon ☐ Leukemia ☐ Lymphoma ☐ Liver ☐ Lung ☐ Melanoma ☐ Testicular ☐ Brain ☐ Ovarian ☐ Cervical ☐ Prostate ☐ Other Cancer ☐ Non-Malignant Tumor – Location of Tumor_____
2 Heart/Circulatory ☐ Yes ☐ No	☐ Aneurysm ☐ Bypass ☐ Angioplasty/Stent ☐ Congestive Heart Failure ☐ Heart Disease ☐ Elevated Cholesterol/Triglycerides ☐ High Blood Pressure ☐ Stroke ☐ Angina ☐ Hemophilia ☐ Blood Clots ☐ Pacemaker/ICD ☐ Blood Disorder ☐ Sickle Cell Anemia ☐ Other_____
3 Reproductive ☐ Yes ☐ No	☐ Current Pregnancy (due date_____ if multiples #_____) ☐ Pregnancy Complications ☐ Fibroids ☐ Menstrual Disorders ☐ Breast Disorders ☐ Endometriosis ☐ Infertility ☐ Other_____
4 Intestinal/Endocrine ☐ Yes ☐ No	☐ Chronic Pancreatitis ☐ Colon Disorder ☐ Crohn's ☐ Ulcerative Colitis ☐ Diabetes ☐ Cirrhosis ☐ Hepatitis B/C ☐ Reflux ☐ Liver Disorder ☐ Ulcer ☐ Growth Hormones ☐ Gallbladder ☐ Gastric Bypass ☐ Other_____
5 Brain/Nervous ☐ Yes ☐ No	☐ Alzheimer's ☐ Cerebral Palsy ☐ Migraines ☐ Multiple Sclerosis ☐ Paralysis ☐ Seizures/Epilepsy ☐ Parkinson's Disease ☐ Head Injury ☐ Cyst ☐ Other_____
6 Immune ☐ Yes ☐ No	☐ Scleroderma ☐ ALS ☐ Psoriasis ☐ AIDS ☐ HIV+ ☐ Lupus ☐ Immuno Deficiency ☐ Other_____
7 Lung/Respiratory ☐ Yes ☐ No	☐ Allergies ☐ Asthma ☐ Cystic Fibrosis ☐ Emphysema ☐ Sarcoidosis ☐ Lung Disorders ☐ Tuberculosis ☐ Sleep Apnea ☐ Chronic Bronchitis ☐ Pneumonia ☐ Other_____
8 Eyes/Ears/ Nose/Throat ☐ Yes ☐ No	☐ Acoustic Neuroma ☐ Cataracts ☐ Cleft Lip/Palate ☐ Deviated Septum ☐ Glaucoma ☐ Retinopathy ☐ Chronic Ear Infections ☐ Chronic Sinusitis ☐ Other_____
9 Urinary/Kidney ☐ Yes ☐ No	☐ Kidney Stones ☐ Kidney Disorders ☐ Bladder Disorders ☐ Polycystic Kidney Disease ☐ Prostate Disorder ☐ Renal Failure ☐ Other_____
10 Bones/Muscles ☐ Yes ☐ No	☐ Rheumatoid Arthritis ☐ Osteoarthritis ☐ Bulging/Herniated Disc ☐ Joint injury ☐ Fibromyalgia/Chronic Fatigue Syndrome ☐ Chronic Pain Syndrome ☐ Shoulder Disorder ☐ Knee Disorder ☐ Spina Bifida ☐ Back Disorder ☐ Neck Disorder ☐ Other_____
11 Behavioral Health ☐ Yes ☐ No	☐ Anxiety/Depression ☐ ADHD ☐ Bipolar Depression ☐ Manic Depression ☐ Schizophrenia ☐ Autism ☐ Eating Disorder ☐ Suicide Attempt ☐ Inpatient Alcohol/Drug ☐ Inpatient Mental Health Hospital ☐ Substance Abuse ☐ Other_____
12 Transplant ☐ Yes ☐ No	☐ Bone Marrow ☐ Organ ☐ Discussed Possible Future Transplant ☐ Stem Cell ☐ Transplant Complications ☐ Other_____
13 Other ☐ Yes ☐ No	☐ Condition not mentioned above with claims in excess of $5,000 ☐ Disability ☐ Congenital Disorder
14 Tobacco ☐ Yes ☐ No	☐ Anyone on this enrollment form used tobacco products in the past 12 months: Person_____
15 Medications ☐ Yes ☐ No	☐ Current Medications: Person _____ # of Meds ___ Person _____ # of Meds ___ (list meds below) ☐ Medications taken within the past 12 months: Person _____ # of Meds ___ Person _____ # of Meds ___ (list meds below)

Please give details of all "yes" answers above. (If additional space is required, please attach a separate sheet and date and sign that sheet).

Question #	Person	Condition/Diagnosis	Treatment /Meds	Physician's Name	Dates Treated	Prognosis

Prior Medical Coverage Information

☐ Yes ☐ No Have you or any dependents applying for coverage been covered by this employer's prior group medical plan?

☐ Yes ☐ No Have you or any dependents applying for coverage been covered by any medical plan other than this employer's prior group plan?
If yes:

Insurance Company Name _____ Phone # _____ Policy/Group # _____

Termination Date _____ Effective Date _____ Reason for Termination_____

Who was covered? _____

Type of Plan: ☐ Prior Employer Group Plan ☐ Spouse's Employer Group Plan ☐ Individual Policy ☐ Other _____

Signature

I declare that all statements and responses contained in this entire form, and in any other health insurance administration and/or coverage application form that I completed within the last 90 days that was provided to All Savers, are true and correct and that no material information has been withheld or omitted. I also understand that the information provided on this form is used to make decisions regarding eligibility and pricing. I understand that misrepresentation, concealment or omission of fact, or a mistake of fact (whether or not a mutual mistake), could materially affect the underwriting, premium, rating or terms and conditions of my employer's Excess Loss Insurance Policy ("Policy") which could result in changes to the terms and conditions of my employer's Excess Loss Insurance Policy, including retroactive increased premium rates and attachment points, or termination of that Policy. I also understand that willful or intentional misrepresentation, concealment or omission of any material fact affecting terms, conditions, or underwriting of my employer's Excess Loss Insurance Policy could result in that Policy being null and void in its inception.

I understand and agree that the Plan Sponsor is not bound by any statement made by or to any agent unless written herein. I agree that no medical benefits will be effective until the date specified in the Summary Plan Description. If I am now waiving medical coverage for myself and/or for my dependents, I have read the entire Waiver provision and understand the enrollment requirements if I make a request for such coverage at a later date.

Coverage is effective only after approval and satisfaction of any probationary period.

In some states, any person who, knowingly and with intent to defraud an insurance company or plan administrator, submits an enrollment application form or files a claim containing any materially false information may be guilty of fraud, which is a crime.

All pages must be attached and complete, including this authorization, for the enrollment application form to be considered complete. Incomplete enrollment application forms may be rejected.

Authorization to Disclose Medical Information for Enrollment

I hereby authorize those physicians, medical practitioners, hospitals, clinics, veterans administration facilities, pharmacy benefit managers, medical information services, urgent care facilities, and other medical or medically related entities, insurance or reinsurance companies, and consumer reporting agencies that have information available as to the present or former physical health condition, including drug or alcohol abuse, and/or treatment of me or my dependents proposed for coverage to release any and all such information, including, but not limited to, medical records, health care provider notes, laboratory tests and results, diagnoses, treatment, and prognoses. I understand the information obtained by use of this authorization may be used to determine eligibility for issuance of health coverage for me and my dependents. This authorization is not applicable to psychotherapy notes.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall expire 15 months after the termination of any coverage I obtain. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. Any information obtained will not be released to any person or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my enrollment for the coverage, for any claim, for medical management purposes, or as may be otherwise lawfully required or as I may further authorize.

Enrollee Signature X _____

Date _____

If signed by a representative of enrollee, please indicate the representative's legal authority to act on behalf of enrollee.

_____

Waiver (Please complete if you are waiving medical coverage.)

I waive medical coverage for: ■ Self (and dependents) ☐ Spouse ☐ Dependent Children	Please state reason for waiving coverage: FOUND OTHER PLAN Qualifying Coverage: None Other _____

If I have waived coverage for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in the plan, provided that I request enrollment within 31 days after my other coverage ends because of involuntary loss of other coverage (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll my dependents, provided that I request enrollment within 31 days after the date of the event.

Applicant Signature X SIDDHARTHA PACHIMATTALA Date 11/14/2019

YOUR RIGHTS REGARDING THE RELEASE AND USE OF GENETIC INFORMATION

The results of any genetic test, including genetic test information, shall not be used as the basis to (1) terminate, restrict, limit or otherwise apply conditions to the coverage of an individual or family member under the plan, or restrict the sale of the plan to an individual or family member; (2) cancel or refuse to renew the coverage of an individual or family member under the plan; (3) deny coverage or exclude an individual or family member from coverage under the plan; (4) impose a rider that excludes coverage for certain benefits or services under the plan; (5) establish differentials in monthly costs or cost-sharing for coverage under the plan; (6) otherwise discriminate against an individual or family member in the provision of insurance.

UnitedHealthcare®

We do not treat members differently because of sex, age, race, color, disability or national origin. If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 7:30 a.m. to 5:30 p.m. CST.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card TTY 711, Monday through Friday, 7:30 a.m. to 5:30 p.m. CST.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說**中文 (Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：**日本語(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**ស្មៅជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.