Employee Name

_____

Employee Health Application Form

Section 1: Employer Information

Employer Name: _____ Hire Date: _____

Section 2: Employee Information

Employee Name:

_____ Date of Birth:_____

Last First M.I.

Address: City State Zip Job Title

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed

Home Phone: ( )_____ Cell Phone: ( )_____

E-mail Address:_____ Hours Worked per Week: _____

Spouse's Employer:_____ Spouse's Business Phone ( )_____

Section 3: Other Insurance Coverage

Are you or any dependent(s) disabled ☐ YES ☐ NO

Do you or your spouse have other health insurance coverage that will continue in addition to this coverage? ☐ Yes ☐ No

If YES, name of Carrier: _____

Policy Holder's Name:_____ Policy #:_____ Effective Date: _____

Name of Covered Dependents:_____

Section 4: Subscriber / Dependents (Please complete for employee subscriber and all participating dependents.)

First Name Last Name	Relationship (Spouse, Son, Daugher)	Social Security #	DOB	Age	M / F	Tobacco Use YES / NO
	Employee					

Section 5: Participation

☐ I Decline Participation. Provide reason below:

Reason for decline:

☐ Spouse's Employer's Plan ☐ Individual Plan ☐ Medicare ☐ Medicaid ☐ COBRA from Prior Employer

☐ VA Eligibility ☐ I (we) have no other coverage at this time ☐ Other:_____

☐ I elect to participate. Please select your plan and Coverage Level below:

Medical

☐ Employee Only	☐ Plan 1
☐ Employee/Spouse	☐ Plan 4 HSA
☐ Employee/Child(ren)	☐ Plan 5 HSA
☐ Family	☐ Plan 6
	☐ Plan 7 HSA

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Dental

☐ Employee Only	☐ Plan 1
☐ Employee/Spouse	☐ Plan 2 Ortho
☐ Employee/Child(ren)	☐ Plan 3 Max 2,000
☐ Family	☐ Plan 4 Ortho Max 2,000

Vision

☐ Employee Only	☐ Plan 1
☐ Employee/Spouse	
☐ Employee/Child(ren)	
☐ Family	

Basic Life: Employer Paid

15, 000 Life Insurance with Medical Beneficiary:_____

Voluntary Life: Employee Paid

You may apply for maximum Guarantee Issue during initial enrollment without answering health questions.

	Guarantee Issue	Amount	Cost
☐ Employee: 10,000-300,000 in increments of 10,000	200,000		$
☐ Spouse: 5,000-150,000 in Increments of 5,000	25,000		$
☐ Child(ren): 1,000-10,000 in increments of 1,000			$

Section 6: Health Information

Please furnish height and weight for you and your dependents:

Self: Height_____ Weight_____lbs Spouse: Height_____ Weight_____lbs

Child: Height_____ Weight_____lbs Child: Height_____Weight_____lbs

Child: Height_____ Weight_____lbs Child: Height_____Weight_____lbs

Please answer the following health questions regarding any medical conditions or medical treatment for you and your family. Note if the answer is Yes to any of these questions you may be asked to fill out an aditional questionnaire.

1. Have you or any of your dependents(s) been diagnosed or treated for any of the following conditions in the past five (5) years?

A. Cardiac Disorder	☐ Yes	☐ No	H. AIDS/HIV/Immune System Disorder	☐ Yes	☐ No
B. Cancer/Tumor(any form)	☐ Yes	☐ No	I. Alcohol/Drug Abuse	☐ Yes	☐ No
C. Diabetes	☐ Yes	☐ No	J. Mental/Nervous Disorder	☐ Yes	☐ No
D. Kidney Disorder	☐ Yes	☐ No	K. Neuromuscular Disord	☐ Yes	☐ No
E. Respiratory Disorder	☐ Yes	☐ No	L. Stomach/Gastrointestinal	☐ Yes	☐ No
F. Liver Disorder	☐ Yes	☐ No	M. Arthritis, Back, Bone, Joint Disorder	☐ Yes	☐ No
G High Blood Pressure	☐ Yes	☐ No	N. Seizures, Convulsions, Epilepsy	☐ Yes	☐ No
			O. Any Other Medical Condition (not listed)	☐ Yes	☐ No

2. Within the past 5 years, have you or any dependent had an application for insurance declined, postponed, rated, or otherwise modified?..... ☐ Yes ☐ No

3. Have you or any of your dependent(s) had any medical conditions in the past 24 months requiring medical care, prescription Management, surgery, hospitalization or had more the $5,000 in medical expenses? ..... ☐ Yes ☐ No
   If Yes, please provide information on who and for what conditions in space provided below.

4. Are you or any of your dependent(s) anticipation hospitalization or surgery, or had surgery or hospitalization recommended has not been performed? If Yes please provide information below..... ☐ Yes ☐ No

5. Are you or any dependent(s) currently pregnant or suspect you/they may be pregnant?
   If Yes, please provide due date and detail in space provided below..... ☐ Yes ☐ No

If you answer "Yes to any of the questions above, please provide detail in space provided below. (If needed, please attach additional sheets, signed and dated by the employee subscriber.)

Employee Name

_____

Question Number	Family Member	Disease/Diagnosis/ Treatment	Date of Onset Month/Year	Date last seen by Physician	Remaining Symptoms or Problems

6. Prescriptions/Medications-List any medications, prescriptions, or injections taken in the last 12 months.(Attach additional sheets as Necessary).

Family Member	Medication/RX/Injection	Dosage	Medical Condition

Section 7: Signature

Unless waived above, I request insurance under my employer's insurance plan as it is now or as it may be amended in the future. I authorize my employer to make deductions from my earnings for my share of the cost, if any, for the benefits to which I may become entitled. I represent that all statements and answers made in this application or any medical questionnaires are complete and true, and I understand that answers will be the basis of any coverage issued. I also understand that all statements and answers made in this application will be valid for 60 days from the date signed. I authorize Wyoming Chambers Health Benefit Trust, its authorized representative Hub International, and its re-insurers and consumer reporting agencies, or any other authorized representatives, to obtain, use, and/or disclose certain information about me as indicated below. Hub International or its re-insurers may obtain and maintain Protected Health Information (PHI) about me to perform specific functions. This Authorization describes the type of information that is collected and my rights regarding how that information can be used. Protected Health Information (PHI) includes individually identifiable health information that is created or received by my provider, my health plan or insurer, a data clearinghouse, a health authority, employer, school or university. PHI can be maintained or transmitted in any form or medium. It relates to the past, present, or future:

- **condition of my physical or mental health;**
- **health care provided to me; or**
- **payment for the health care provided to me.**

PHI does not include summary health information or information that has been de-identified according to the standards for de-identification provided for in the HIPAA Privacy Rule. This information may be obtained from a number of sources including, but not limited to, applications for health plan coverage, questionnaires, health care providers, claims for payment filed by myself or health care providers, referrals made by health care providers, and my medical records. Other sources of PHI include group health plan administrators, insurance carriers, the Medical Information Bureau, employers, and other business partners such as pharmacy benefit managers, third-party administrators, consultants, agents or brokers. PHI may be obtained over the telephone, by mail, or e-mail. PHI may be used by Hub International or its re-insurers sales and underwriting personnel, legal, or others as necessary in order to provide insurance coverage. Additionally, PHI may be used by, and disclosed to other business partners, such as agents or brokers, for the purpose of determining eligibility for coverage. Hub International and/or its insurers are committed to the privacy of your PHI and have required all business associates and vendors to agree in writing to those same protections. Despite these efforts, we are required by law to advise you that your information may at some point fall outside of these protections. I understand I have a right to inspect and copy my own PHI to be used or disclosed. I also understand that failure to sign this Authorization will result in my application not being considered. I agree this Authorization will be valid until Hub International and/or its re-insurers has completed its determination of my eligibility for coverage.

Employee Signature:_____**Date:**_____