

**KENTUCKY
GROUP INSURANCE
EMPLOYEE ENROLLMENT FORM**



**PRINT ALL INFORMATION - USE INK, NOT PENCIL
TO BE COMPLETED BY THE EMPLOYEE**

Group # _____ Certificate # _____ Name of Employer _____

Employer Phone # (_____) _____ Employer Fax # (_____) _____

Check One: 1st Enrollment Adding Dependent(s) Adding Medical Other _____ (Date of Marriage/Birth) _____

A. EMPLOYMENT AND PERSONAL INFORMATION

Name of Employee _____

Last First MI

Home Address _____

Street City/State Zip

Home Phone (_____) _____ Male Female Single Married

Full-time Employment date: ____/____/____/ **Job Duties:** _____

Hours Worked Per Week: _____ **Monthly Earnings: \$** _____ **Earning Basis:** Salaried Hourly Commission

Earning Type: W2 1099 Owner/Partner
 Other _____

Employee Status: Active Continuation COBRA Disability Retired Other Leave **Effective Date of COBRA/Continuation or Other**
Leave: (Month/Day/Year) ____/____/____

B. COVERAGE REQUESTED (Medical history [Section D] required for Medical, Life & DI coverage only)

Life/AD&D AMOUNT: \$ _____,000 **Short Term Disability Amount:** \$ _____

Name of Beneficiary _____ SS# _____-____-____

Relationship to Employee _____

If no beneficiary is designated, death benefits will be payable to your estate.

Dependent Life Coverage: N/A Yes

Medical: None* Single Employee & Spouse Employee & Children Full Family
Groups with multiple medical plans, indicate which plan you are requesting Plan 1 Plan 2 Plan 3 Plan 4

**If waiving Medical coverage on yourself or your dependents, please fully complete Section F.*

Dental: None* Single Employee & Spouse Employee & Children Full Family

**If waiving Medical coverage on yourself or your dependents, please fully complete Section F.*

C. PERSONS TO BE COVERED (If more space is needed, attach an additional piece of paper.)

Name (Include yourself and all family members to be insured)		Relationship	Date of Birth (Mo/Day/Yr)	Social Security Number	Current Height (Ft/In)	Current Weight (Lbs)	Has tobacco in any form been used in the past 12 months?	Full-time Student (age 19+)
Last Name	First Name							
		Employee	/ /	- -			<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Spouse	/ /	- -			<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Child	/ /	- -			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Child	/ /	- -			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Child	/ /	- -			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Child	/ /	- -			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please explain if any child listed above is (a) not your natural child, legally adopted child or stepchild, (b) not solely supported by you, or (c) not permanently residing in your household: _____

D. HEALTH HISTORY (Give complete details in Section E)

1. Have you or any of your dependents included on this enrollment form :
- a. Within the past 5 years, been confined in a hospital, emergency room or other medical facility OR had medical expenses in excess of \$3,000 in any one year? Yes No
 - b. Have you or any of your dependents included on this form been prescribed medication in the past 18 months?..... Yes No
If yes, please complete the prescription drug information in Section E.
 - c. In the past 18 months, been seen by any health care provider, including routine follow-up or ongoing medical care, any consultation, treatment, therapy, advice or undergone any testing? Yes No
 - d. Been advised of the necessity or possibility of any future treatment, testing or surgery? Yes No
2. Have you or any of your dependents included on this enrollment form within the past 10 years been diagnosed with or treated for any of the following: **(circle all that apply)**
- a. Cancer/Tumor; Chest Pain; Lung Disorders; Heart Attack/Bypass/Angioplasty; Heart Disorders; Vascular Disorders; Systemic Lupus Erythematosus; Hodgkin's/Lymphoma/Leukemia; Blood Disorders; Immune Disorders; Liver Disorder/Hepatitis; Multiple Sclerosis (MS); Stroke; or Tested Positive, Been Treated for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), Sexually Transmitted Diseases? Yes No
 - b. Alcohol or Drug Usage; Asthma; Back Disorders; Muscle Disorders; Arthritis; Skeletal Disorders; Crohn's Disease; Ulcerative Colitis; Digestive Disorders; Urinary Disorders; Kidney Disorders; Seizures; Paralysis; Nervous System Disorders; Ear/Eye/Nose/Throat Disorders; Reproductive Disorders; Endocrine Disorders; Mental or Nervous Disorders; Hypertension/High Blood Pressure; any Other Physical Disorder or Deformity or a Partial or Total Disability? Yes No
If Hypertension/High Blood Pressure circled please provide last 3 blood pressure readings:
current_____ 6 mo._____ 1 yr._____
 - c. Diabetes Mellitus or Diabetic Related Disorders: **(circle all that apply)** Heart Disease, Diabetic Coma, Ketoacidosis, Stroke, Kidney Impairments (Nephropathy), Visual Impairments (Retinopathy), Peripheral Vascular Disease, Nerve Impairments such as Numbness or Burning of Legs or Feet (Neuropathy), Insulin Reaction? Yes No
Diabetes Mellitus type: Type 1 (Juvenile) Type 2 (Adult Onset) Impaired Glucose Tolerance
Date of onset: ___/___/___
Type of treatment: Diet Controlled Oral Medications Insulin Insulin Pump
Include Three Hemoglobin A1c Readings and Dates:.....1. _____ / ___/_____
.....2. _____ / ___/_____
.....3. _____ / ___/_____
3. Are you or any dependents included on this enrollment form currently pregnant, in the process of adoption, undergoing or have undergone infertility treatment? Yes No
If yes, are you anticipating complications for you or your unborn child and/or multiple births? Yes No
Are you anticipating a cesarean section? Yes No
Due Date/Date of Adoption: _____/_____/_____

E. PLEASE GIVE COMPLETE DETAILS TO ALL MEDICAL QUESTIONS THAT HAVE BEEN ANSWERED YES.

Complete all columns, if more space is needed, attach an additional sheet of paper which must be signed and dated.

PRESCRIPTION DRUG INFORMATION

Individual (Full Name)	Name of Medication	Dosage and Frequency of Use	Date Prescribed	Date Last Used	Condition(s) Being Used For

Question # and/or Itr	Individual (Full Name)	Nature of Condition and/or Diagnosis	Duration Dates From To	Explain Treatment: Include date of Disability, Hospitalization, Tests and Surgery	Results/Degree of Recovery

F. WAIVER OF COVERAGE:

This section must be completed if you or your dependents DO NOT want coverage.

I understand that I am eligible to apply for coverage through my employer. I **DO NOT** want coverage for (check all that apply):

Person Waiving	Coverage Waived	Reason for Waiving	Carrier Information
<input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Children	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Coverage under spouse's group plan <input type="checkbox"/> Individual medical plan <input type="checkbox"/> Medicare/Medicaid <input type="checkbox"/> Other _____	Carrier Name: _____ Policy Number: _____ OR (Provide a copy of the ID card)

G. PRIOR INSURANCE COVERAGE INFORMATION

Failure to supply complete information may result in a pre-existing condition limitation.

Have you, your spouse or dependent children been covered by any type of medical plan within the last 18 months? Yes No
If yes, list all plans in effect during the past 18 months.

Have you, your spouse or dependent children been covered by a dental plan within the last 12 months? Yes No
If yes, list all plans in effect during the past 18 months.

Covered Persons	Insurance Company Name/Telephone/Policy #	Effective Date	Termination Date	Reason for Termination
<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child				
<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child				

Will any current medical and/or dental plan terminate if coverage is approved by Fortis Benefit Insurance Company? Yes No
If Yes, for whom

H. 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 the statements and answers contained herein will be used by Fortis Benefits Insurance Company to determine eligibility for insurance for myself and persons listed on this enrollment form as my spouse or dependent children.

When applicable, I authorize my employer to deduct contributions from my earnings to be applied to the cost of insurance.

I understand that (1) the answers given will be the basis of any coverage provided; (2) coverage, if approved, may be subject to limitations regarding preexisting conditions as defined by the certificate of insurance; (3) any material misrepresentation or failure to provide completed information to questions on this enrollment form may be used as a basis for changing rates or terminating my coverage; (4) if coverage is not approved, I, my spouse or dependent children are not entitled to benefits; (5) if I, my spouse or dependent children waive coverage and decide to apply for coverage at a later date, evidence of insurability may be required and benefits may be deferred for a specified period of time; and (6) coverage will not be effective until I receive notice that this enrollment form has been approved by Fortis Benefits Insurance Company.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give the Fortis Benefits Insurance Company, or its reinsurers, any such information.

Information regarding your insurability will be treated as confidential. Fortis Benefits Insurance Company, or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its Members. If you apply to another bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address in the Bureau's information office is Post Office, Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

I agree that a copy of this authorization will be valid as an original.

I understand that this authorization is required in order to enable Fortis Benefits Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for Fortis Benefits Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Fortis Benefits Insurance Company may refuse to consider my application for enrollment.

This authorization expires upon the earliest of the following events: denial of my application, declination of enrollment, or if insured, when I am no longer an insured of Fortis Benefits Insurance Company, but in no event will this authorization be in effect for longer than 24 months from the date signed.

Any person who knowingly and with intent to defraud any insurance company or other person submits an enrollment form for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I understand that the agent submitting this enrollment form represents my interests, not those of Fortis Benefits Insurance Company. The agent has no right to bind coverage, to alter the terms of insurance coverage or enrollment form in any manner, or to adjust any claim for benefits.

Signature of Proposed

Insured _____

Date _____

Please Note:

- 1) Fortis Benefits Insurance Company is not responsible for enrollment forms not sent to us in a timely manner.
- 2) Effective dates are subject to underwriting approval.
- 3) Please retain a copy for your records.