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**WARNING:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is guilty of insurance or health care fraud under state and/or federal law.

- New Application Only**  
**Coverages Elected**  
 Medical   
 Dental   
 Vision   
 LTD   
 Life/AD & D

**MICHIGAN EMPLOYEE APPLICATION – LESS THAN 50 COVERED MEDICAL LIVES ENROLLING**

**READ CAREFULLY AND COMPLETE IN INK TO PREVENT YOUR COVERAGE FROM BEING DELAYED. COMPLETE ALL SECTIONS OF THE APPLICATION. SIGN AND DATE THE AGREEMENT AND AUTHORIZATION. IF YOU WANT LIFE ONLY COVERAGE, YOU MUST COMPLETE THE ENTIRE APPLICATION. IF YOU ARE APPLYING FOR SPOUSAL COVERAGE, HAVE YOUR SPOUSE SIGN AND DATE THE AGREEMENT AND AUTHORIZATION.**

**1** Employee Information (Please print in ink):

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Last First Middle Initial

Home Address \_\_\_\_\_ Telephone ( ) \_\_\_\_\_  
Street City State Zip

<b>Employee Date of Birth</b> ____/____/____ Mo. Day Yr.	<b>Sex</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Marital Status</b> <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Common Law*	<b>Who Is to Be Insured</b> <input type="checkbox"/> Life Only Coverage <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Employee and Children <input type="checkbox"/> Employee, Spouse & Children	<b>Date Hired</b> ____/____/____ Mo. Day Yr.
<b>Earnings</b> \$ _____ <input type="checkbox"/> Yearly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	<b>Height</b> _____ <b>Weight</b> _____			<b>COBRA Election Date</b> ____/____/____ Mo. Day Yr

Employed by \_\_\_\_\_  
Company Name City, State of Employment Group/Account Number

Occupation \_\_\_\_\_ Hours Worked Weekly \_\_\_\_\_

Beneficiary Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Last First MI

\* Complete Supplemental Information - Common Law Relationship

**2** **EMPLOYEE LIFE ONLY COVERAGE – WAIVER OF COVERAGE**

**All eligible employees must enroll for Life and AD&D, and if included in the employer’s plan, Disability coverage.**

If you are declining enrollment for yourself or your dependents (including your spouse) because you have other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or your appointment as a legal guardian, you may be able to enroll yourself and/or your dependents, provided that you request enrollment within 30 days after the date of the marriage or appointment of legal guardianship, or 31 days of a birth, adoption, or placement for adoption. This plan will also allow enrollments as necessary to comply with the terms of medical child support orders, or qualified medical child support orders, as defined in applicable state or federal law. Other than as described above, you may not be eligible to enroll in this plan if you waive coverage at this time or may be subject to an additional waiting period, beginning with the date of late enrollment.

I hereby waive ALL coverages except employee only group term life insurance. **(Employee signature required on reverse.)**

I hereby waive THE FOLLOWING coverages. **(Check all that apply. Employee signature required on reverse.)**

All Dental Coverage       All Dependent Medical Coverage       All Dependent Vision Coverage

All Vision Coverage       All Dependent Dental Coverage       Other \_\_\_\_\_

**COMPLETE FOR DEPENDENT COVERAGE, including SPOUSE**

**Dependent coverage is not available for AD&D or Disability Insurance.**

**If you do not wish to cover your eligible dependents, please complete the Waiver of Coverage section above.**

Spouse Name	Date of Birth	Height/ Weight	S.S. Number	Male or Female

Spouse employed?  Yes  No If "Yes", employed by \_\_\_\_\_ Date of Marriage: \_\_\_\_\_

Spouse insured elsewhere?  Yes  No If "Yes", insured by \_\_\_\_\_ Policy Number: \_\_\_\_\_

**Dependent Children:**

Relationship (Check one)

Full Name	Date of Birth	Height/ Weight	Male or Female	Full-Time Student? (Y/N)	You and/or your spouse provide over 50% support?	Natural Child	Adopted Child*	Step-Child	Custody or Guardian-ship*

\*Please attach to this application copies of the court orders or legal documents creating this relationship.

Children insured elsewhere?  Yes  No If "Yes", insured by: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Are any of the other Dependents listed above in the legal custody or guardianship of another Person?  Yes  No  
If yes, please complete the following:

Dependent	Person with Legal Custody	Relationship to Dependent	Address of Custodian

If you are not the parent of any child listed above, does each such child reside with you?

Yes  No If "No", which children do not? \_\_\_\_\_

**MEDICAL HISTORY AND CURRENT CONDITIONS**

1. Yes  No  Have you or any dependents (to be covered) incurred medical expenses or had medical claims in excess of \$4,000.00 in the past five years?
2. Yes  No  Are you or any dependents (to be covered) currently disabled, missed work or been unable to perform your regular daily activities for more than 5 consecutive days because of any illness or injury during the past 2 years?
3. Yes  No  Have you or any dependents (to be covered) had an inpatient admission or surgery, or outpatient surgery in the past 5 years or is any admission or surgery anticipated in the next 12 months?
4. Yes  No  Are you or any of your dependents (to be covered) currently pregnant? If so, please submit due date for current pregnancy and details regarding any previous pregnancies.
5. Have you or any dependents (to be covered) ever been diagnosed, treated, or had any indication of:
 

a. Yes <input type="checkbox"/> No <input type="checkbox"/> Arthritis	l. Yes <input type="checkbox"/> No <input type="checkbox"/> Diabetes / endocrine disorder
b. Yes <input type="checkbox"/> No <input type="checkbox"/> Tumor / Cancer	m. Yes <input type="checkbox"/> No <input type="checkbox"/> Nervous / psychiatric disorder
c. Yes <input type="checkbox"/> No <input type="checkbox"/> Liver disorder	n. Yes <input type="checkbox"/> No <input type="checkbox"/> Blood / immune system disorder
d. Yes <input type="checkbox"/> No <input type="checkbox"/> Bladder disorder	o. Yes <input type="checkbox"/> No <input type="checkbox"/> Asthma / respiratory disorder
e. Yes <input type="checkbox"/> No <input type="checkbox"/> Heart disease	p. Yes <input type="checkbox"/> No <input type="checkbox"/> High risk pregnancy / infants
f. Yes <input type="checkbox"/> No <input type="checkbox"/> Multiple trauma	q. Yes <input type="checkbox"/> No <input type="checkbox"/> Alcohol or drug abuse
g. Yes <input type="checkbox"/> No <input type="checkbox"/> Kidney disease	r. Yes <input type="checkbox"/> No <input type="checkbox"/> Gallbladder / digestive disorder
h. Yes <input type="checkbox"/> No <input type="checkbox"/> Prostate trouble	s. Yes <input type="checkbox"/> No <input type="checkbox"/> Heart / circulatory disorder / stroke
i. Yes <input type="checkbox"/> No <input type="checkbox"/> High / low blood pressure	t. Yes <input type="checkbox"/> No <input type="checkbox"/> Developmental Birth Defects
j. Yes <input type="checkbox"/> No <input type="checkbox"/> Epilepsy / seizure disorders	u. Yes <input type="checkbox"/> No <input type="checkbox"/> Sexually transmitted diseases
k. Yes <input type="checkbox"/> No <input type="checkbox"/> Chronic conditions / diseases	v. Yes <input type="checkbox"/> No <input type="checkbox"/> Eye, ear, nose, throat disorders

**LIST ALL PRESCRIPTIONS YOU AND/OR YOUR DEPENDENT(S) ARE CURRENTLY TAKING AND TO WHOM PRESCRIBED:**

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**FOR ANY RESPONSE MARKED "YES" ABOVE, PLEASE PROVIDE SPECIFIC DETAILS BELOW:**

(Mark each response with number or letter selected above. Information must include: diagnosis, type of treatment(s), dates of treatment(s), dates of hospitalizations (if any), prognosis, medications, and names and phone numbers of attending physicians. Attach additional sheets if necessary.)

**5 Read this Agreement and Authorization Carefully**

I hereby request coverage and authorize that any requested contribution for the insurance to which I may be entitled be deducted from my earnings. I am employed by the employer shown and am working at least the number of hours per week required by my Employer and shown on the Employer Application. I further understand that any failure to comply with the Utilization Review or Second Surgical Opinion procedures may result in a reduction of benefits. I authorize (1) any physician, hospital, or other health practitioner or facility, (2) any insurance company or health care plan, (3) any state or federal agency providing health care benefits, and (4) any employer to provide Medical Benefits Mutual Life Insurance Co. or its legal representative any information in their possession which is relevant to this application for insurance regarding myself or my listed Dependent(s). This information will be used to determine the eligibility for coverage and/or benefits for myself and my listed Dependent(s) and will be utilized by employees and agents of Medical Benefits Mutual Life Insurance Co. with responsibility for (1) reviewing applications and determining eligibility for coverage, (2) payment of claims, and (3) any other health care operations. I hereby authorize and release any provider of health care services, claim administrators, insurers, reinsurers, pharmacy benefit managers, and others who have a legitimate need for such information for the purpose of review, investigation, or evaluation of a claim, to supply each other with information about the health status of, and health care services provided to, me and my listed Dependent(s). I understand that information disclosed by MedBen to any individuals listed in the preceding paragraph pursuant to this authorization may be subject to redisclosure by such individuals, and will no longer be protected by this authorization. This authorization is effective on the date signed and shall remain in effect until coverage is no longer in effect. (You or any individual authorized by law to act on your behalf have a right to receive a copy of this authorization.) A photographic copy of this authorization shall be as valid as the original. I understand that if I fail to provide this authorization, MedBen will be unable to process my application for coverage. I further understand that I have the right to revoke this authorization by submitting such revocation to the Chief Privacy Officer, Medical Benefits Mutual Life Insurance Co. at the address listed on this application. Such revocation will not be effective to the extent that action has been taken in reliance upon this authorization prior to MedBen's receipt of my revocation or to the extent that MedBen has the right to contest my coverage or a claim thereunder under applicable law. I hereby certify that I have personally answered all of the questions on this form and that my answers are true and complete to the best of my knowledge and belief. I have legal proof which I can furnish upon request of my relationship to any person listed as a Dependent above. I understand that any misstatements (including the misstatement of any medical information), or failure to report (including failure to report any medical information), may be used as a basis for rescission or cancellation of the insurance for me and my Dependent(s), if any.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse Signature (if applying for coverage) \_\_\_\_\_ Date \_\_\_\_\_

**I understand that if, upon receipt, the signature is more than 60 days old, a new application will be requested.**