

3PADministrATORS

704 Sand Lake Road Onalaska, WI 54650 Ph: 608-779-3000 Fax: 608-779-3009

EMPLOYER GROUP: _____

For Office Use Only
Effective: _____
Group ID: _____

EMPLOYEE INFORMATION

Last Name:		First Name:		MI:	
Date of birth:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Date of Employment:		Position:	
Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/>		SSN:		Hours Per Week:	
Current address:				Phone:	
City:			State:		Zip:
Select Your Coverage(s):		Single Medical <input type="checkbox"/> Family Medical <input type="checkbox"/>		Where Available: Single Dental <input type="checkbox"/> Family Dental <input type="checkbox"/>	

DEPENDENT INFORMATION

Dependents to be covered: (Include last name if different from employee's)

Spouse:	Date of Birth:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Child 1:	Date of Birth:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Child 2:	Date of Birth:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Child 3:	Date of Birth:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Child 4:	Date of Birth:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Child 5:	Date of Birth:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>

OTHER COVERAGES

As of your effective date, will there be any other group insurance coverage in effect on you or your covered dependents? Yes No

If Yes, give name of **Employer** providing coverage: _____ Name of **Primary Insured**: _____

Please indicate if other medical coverage is: Single <input type="checkbox"/> Family <input type="checkbox"/>	Other dental coverage: Single <input type="checkbox"/> Family <input type="checkbox"/>	Family Members covered under other insurance:
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MEDICAL HISTORY

Have you or any dependent to be covered incurred medical expense in excess of \$10,000 during the last 12 months? Yes No

If Yes, list the name of the person, the condition and degree of recovery: _____

Are you or any covered dependent totally disabled? Yes No

WAIVER OF BENEFITS

I, the undersigned, an employee of the above named policy holder, hereby certify that I have been given an opportunity to apply for group insurance benefits as offered by my employer and after careful consideration, I hereby waive my right to:

Single Medical Coverage Family Medical Coverage

Reason for waiving coverage: _____

MEDICAL RELEASE AUTHORIZATION

By signing this form, I authorize release and disclosure of protected health information (PHI) to 3PADministrators necessary for benefit determination, payment, treatment, or plan operations. PHI includes, but is not limited to, hospital records, physician records, lab results, mental health records, alcohol and/or drug abuse records and HIV testing. 3PA will not further release or disclose PHI received except to reinsurance carriers or as lawfully required. For additional information on any possible release or disclosure, I understand that I can request a copy of 3PADministrators' privacy policy. 3PA will use PHI only for appropriate and accurate determination of medical benefits.

I further authorize 3PADministrators to pay benefits directly to health care providers unless otherwise indicated.
I agree that this authorization is valid for one year from the signature date.
I may revoke this authorization by submitting a written request.

I hereby verify that the information listed above is true and accurate to the best of my knowledge.

Signature of Employee (Required): _____ Date Signed: _____

IMPORTANT INFORMATION ON YOUR RIGHTS AND RESPONSIBILITIES

Special Enrollment Provision

Loss of other coverage. If you decline coverage for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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 toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

New dependent. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact your employer's human resource department.

Pre-existing Condition Provisions

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period prior to your date of hire. Pre-existing exclusions do not apply to pregnancy or to a child who is enrolled in the plan within 30 days of birth, adoption or placement.

This exclusion can last up to 12 months (18 months for a late enrollee). However, you can reduce or eliminate this exclusion period if you had prior creditable coverage and did not experience a break in coverage of 63 days or more. Submit a certificate of creditable coverage from your prior plan to your employer's human resource department to determine if the exclusion period is reduced or eliminated.

Women's Health and Cancer Rights Act Notice

On October 21, 1998, the federal government passed the Women's Health and Cancer Rights Act of 1998. As part of our plan's compliance with this Act, we are required to provide you, at the time of enrollment, with information outlining the coverage this law requires our plan to include.

Our group health plan has always provided coverage for medically necessary mastectomies. This coverage includes procedures to reconstruct the breast on which the mastectomy was performed, as well as the cost of necessary prostheses (implants, special bras, etc.) and treatment of any physical complications resulting from any stage of the mastectomy. However, as a result of this federal law, the plan now provides coverage for surgery and reconstruction of the other breast to achieve a symmetrical appearance with the breast on which the mastectomy is performed.

The following benefits are required to be provided if benefits are provided for a mastectomy:

1. Coverage for reconstruction of the breast on which the mastectomy is performed.
2. Coverage for surgery and reconstruction of the other breast to produce a symmetrical appearance with the breast on which the mastectomy is performed.
3. Coverage for prostheses and physical complications resulting from any stage of the mastectomy, including lymphedemas.

These benefits are subject to the same deductible, co-pays and co-insurance that apply to mastectomy benefits under the plan.