American Trust Administrators, Inc.
7223 W 95th Street, #301, Overland Park KS 66212-2291
SERVICE ORGANIZATION FOR YOUR EMPLOYER'S PLAN

Employee Enrollment / Refusal Form

INSTRUCTIONS FOR COMPLETING THIS FORM

Misstatements and omissions made by you on this form may cause you to lose coverage under your employer's plan. This form must be completed by the **EMPLOYEE ONLY**. Please Print in ink and **INITIAL & DATE** all corrections. You must be a US Citizen or Alien legally residing and working in the USA to be eligible for coverage under this plan.

STEP 1: PLEASE TELL US ABOUT YOURSELF

Last Name	First Name	Middle Initial	Personal Email Address:

Home Street Address	City	State	Zip Code

Sex	Social Security Number	Birth Date	Home Phone	Marital Status (Please check one)
❑ Male ❑ Female	– –	/ /	( ) -	❑ Single ❑ Married ❑ Legally Separated ❑ Divorced ❑ Common Law ❑ Civil Union / Other

Height (Ft/In)	Weight (lbs)	Tobacco User? (Y/N) (Type/Yrs Used)	Hours Worked Per Week:	Job Title:

Date Full-Time Employment Began:	What Company Do You Work For?	Employee Status (Please check one)	Effective Date COBRA/Continuation/Other Leave
		❑ Active ❑ Retiree (not eligible) ❑ COBRA ❑ Other Leave (Please explain)	

STEP 2: PLEASE TELL US ABOUT INDIVIDUALS WHO ARE ELECTING COVERAGE

Only your opposite-sexed spouse, natural children, adopted children, and step-children, are eligible to be enrolled. If the spouse's last name is different than the employee, please provide a copy of the marriage certificate with this enrollment form.

Relation To Employee	Last Name (if different), First Name, initial	Gender (M/F)	Date of Birth	Medicare HIC number if any	Social Security Number	Height (Ft/In)	Weight (lbs)	Tobacco User? (Y/N) Type/Yrs Used
Spouse						/		
❑ Child ❑ Stepchild ❑ Other _____						/		
❑ Child ❑ Stepchild ❑ Other _____						/		
❑ Child ❑ Stepchild ❑ Other _____						/		
❑ Child ❑ Stepchild ❑ Other _____						/		

Does the spouse and/or dependent children named on this enrollment form live with you at the address shown above? ❑ Yes ❑ No If "No", please write their name(s) and full home address if different from yours:

STEP 3: PLEASE TELL US WHAT COVERAGES YOU ARE ELECTING OR DECLINING FOR ALL FAMILY MEMBERS (even those not listed above) - Check "No" to decline a coverage

PERSON	MEDICAL	DENTAL— If offered by your employer	SELECTION of HEALTH PLAN Option ❑ High ❑ Medium ❑ Low ("high" means best benefits and highest costs and so on)
Employee	❑ Yes ❑ No	❑ Yes ❑ No	
Spouse	❑ Yes ❑ No	❑ Yes ❑ No	
Children	❑ Yes ❑ No	❑ Yes ❑ No	

STEP 4: PLEASE TELL US WHY YOU ARE DECLINING COVERAGE (If you checked "No" in Step 3 for any person)

Employee	❑ Medicare* or Medicaid	❑ Other Health Coverage – Please tell us the other plan name	❑ Other Reason – Please explain
Spouse	❑ Medicare* or Medicaid	❑ Other Health Coverage – Please tell us the plan name	❑ Other Reason – Please explain
Children	❑ Medicare* or Medicaid	❑ Other Health Coverage – Please tell us the plan name	❑ Other Reason – Please explain

*** Loss of coverage under Medicare cannot be used as the basis to waive the 6-month waiting period for late enrollees.**

STEP 5: HEALTH STATEMENT – Please complete for only those persons electing coverage

You may be asked to call a medical underwriter to answer questions about any health information you are providing and/or missing information on this form. This interview may be recorded for quality assurance. **DAYTIME PHONE NUMBER ( ) _____ – _____**

1. Within the **past 5 years**, based upon other than the results of genetic testing, have you, your spouse, or dependent children been tested, treated **(including the use of prescription medication)**, been advised to seek treatment for, or diagnosed as having:

A.	Arthritis, Bone, Joint, Spine, Muscle or Connective Tissue Disorder	❑ Yes ❑ No
B.	Bone Marrow or any Organ Transplant or replacement	❑ Yes ❑ No
C.	Urologic Disorders or any Disorder of the Kidney; or Cirrhosis, Hepatitis or other diseases of the Liver	❑ Yes ❑ No
D.	Digestive System Disorder, including Diseases of the Colon, Gallbladder, Pancreas, Stomach, Esophagus or Intestines	❑ Yes ❑ No
E.	Diabetes, Thyroid Disorder or Disease of the Endocrine System	❑ Yes ❑ No
F.	Drug Abuse, Alcohol Abuse, Fetal Alcohol Syndrome or Psychiatric Disorder including ADD & ADHD	❑ Yes ❑ No
G.	Eye, Ear, Nose, and/or Throat Disorder	❑ Yes ❑ No
H.	Genetic, Growth or Developmental Disorder (do not disclose genetic disorders that have not manifested to the point that they could be diagnosed by a physician based upon the presence of physical symptoms).	❑ Yes ❑ No
I.	Rheumatic Heart Disease, Heart Disorder, Circulatory Disorder, Blood Disorder (including High Blood Pressure) or Edema Ever had a Heart Attack: Yes:# of times:_____ List Date(s):_____	❑ Yes ❑ No

J.	Lupus or other autoimmune disorder or disease; an Immune System Disorder, including disorder of the Spleen, AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)	❑ Yes ❑ No
K.	Metabolic and Nutritional Disorders (including high cholesterol)	❑ Yes ❑ No
L.	Quadriplegia, Paraplegia, Hemiplegia or Congenital Disorder	❑ Yes ❑ No
M.	Neurological Disorder, including Alzheimer's Disease, Brain Disorders, Cerebral Palsy, Epilepsy, Migraines, Parkinson's Disease, Seizures, Multiple Sclerosis, or Meningitis	❑ Yes ❑ No
N.	Reproductive System Disorder including Infertility Treatment	❑ Yes ❑ No
O.	Respiratory Disorder, Cystic Fibrosis or Sleep Disorder	❑ Yes ❑ No
P.	Have you ever had a child born prematurely?	❑ Yes ❑ No
Q.	Are you or any of your dependents currently pregnant, an expectant parent, or has anyone to be covered ever had any complications of pregnancy, or are you or any of your dependents currently in the process of adopting a child? **Due Date or expected date of adoption:** _____	❑ Yes ❑ No
R.	Vascular Disorders including stroke, CVA (Cerebrovascular Accident) or TIA (Transient Ischemic Attack)	❑ Yes ❑ No
2.	Do you, your spouse, or dependent children have any condition (other than genetic disorders which have not physically manifested) that may require diagnostic testing, medical appliances, medical, surgical, or hospital care, or any condition, illness, or injury for which a physician has not yet been consulted? If "yes", list the condition here :_____	❑ Yes ❑ No
3.	Are you or any of your dependents **currently** disabled or **have been** disabled within the past 5 years? If "yes", state the cause of the disability here:_____	❑ Yes ❑ No
4.	Have you or any of your dependents ever been diagnosed with any form of Cancer? Type:_____ Date Diagnosed:_____Prognosis:_____Remission: ❑ Yes ❑ No, when:_____ Cancer Stage:_____ Chemotherapy ❑ Yes ❑ No, Radiation ❑ Yes ❑ No Last date of chemo or radiation_____	❑ Yes ❑ No

5. **List All Prescribed Medication Taken and Condition(s)for which the drug was prescribe (attach a signed, separate sheet if needed):**

Name of person	Drug prescribed	Dosage	Condition for which prescribed

6. For any "Yes" answer given to any sub-question (A to R) of question 1 of Step 5, please fully complete the following information (Please complete on back of form or attach a separate signed sheet if more space is needed):

Letter of the sub-question	Person's First & Last Name	Diagnosis AND Date Diagnosed	Treatments Received/ Required OR Recommended	Surgeries Received/Required OR Recommended	Doctor's Name/Phone Number
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

STEP 6: NOTICES, REPRESENTATION & AUTHORIZATION – Please read this section carefully then sign & date the form below

SPECIAL ENROLLMENT NOTICE

If you decline medical and/or dental coverage for yourself, your spouse, or your dependents at this time for any reason, you may later be eligible to enroll yourself, your spouse and/or your newly acquired dependent(s) in medical and/or dental coverage within 30 days of acquiring the dependent(s) through marriage, birth, adoption, or placement for adoption. If you decline medical and/or dental coverage for yourself or your dependents at this time because of coverage under other health insurance or group health plan coverage, you or your dependents may later be eligible to apply for medical and/or dental coverage without penalty within 30 days after you or your dependents' other health coverage ends (or after the employer stops contributing toward the other coverage), **but only if you state in STEP 4 that other health coverage is the reason for declining coverage.** The penalty for failure to state that other health coverage was the reason for declining this coverage will be a 6-month waiting period under this plan after you apply for coverage hereunder.

I represent: (1) I am an employee of the participating employer and the persons for whom I am requesting coverage are US Citizens or Legal Aliens residing in the USA; (2) the statements and answers to the questions on this Enrollment/Refusal Form made by me are true and complete to the best of my knowledge; and (3) I understand that the statements and answers to questions on this Enrollment/Refusal Form made by me and any subsequent information I provide are the basis for my coverage under my employer's plan and coverage will not be effective until I am notified of my effective date.

I authorize: (1) any physician, medical practitioner, hospital, clinic, pharmacy benefit managers, Veteran's Administration, or other medical-related facility, insurance agent, administrator, insurance company, reinsurer, consumer reporting agency, telephone interview company, or my employer to release any information pertaining to my employment or to the health of myself or my dependents, including physical or mental disorders or the use of drugs and alcohol, to American Trust Administrators, Inc.; (2) American Trust Administrators, Inc. to release such information to any insurance agent, insurance company, reinsurer, managed care organization, telephone interview company, other insurance support organization, or my employer; (3) my employer to deduct contributions from my earnings to be applied to the cost of this plan; and (4) that benefits under this plan be paid directly to any managed care provider utilized by me or my family.

I agree this authorization will be valid for two years from the date this form is signed and that a photocopy of this authorization is as valid as the original for my dependents and me. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of a crime.

Employee Signature **X**_____ **Date Signed** ____/____/_____

(PLEASE DO NOT PRINT)