CALIFORNIA
GROUP INSURANCE
EMPLOYEE ENROLLMENT FORM

FORTIS
Solid partners, flexible solutions℠

EMPLOYEE INFORMATION

EMP

This is a: ❑ New Enrollment ❑ Change of Coverage – Employee # ______________

Case # (if existing) ________________ Business Name ________________________________

PRINT ALL INFORMATION – DO NOT PUNCTUATE – USE INK, NOT PENCIL

	FIRST	INIT	LAST	SUFFIX (if any)
Employee Name				

Employee Sex			Marital Status
❑ Male ❑ Female	SS# – –	Birthdate – –	❑ Single ❑ Married

Spouse's First (if applying) Name	INIT	SS# – –	Birthdate – –

Employee Address

STREET		
STREET		
CITY	STATE	ZIP CODE

Home Phone # (   ) ______________

Date Employed Full-Time: MONTH DAY YEAR

Requested Effective Date: ____/____/____ (New employees may only request coverage on 1st of the month)

Annual Salary: ____________

Job Duties: ________________________________

Do you regularly work for this employer at least 30 hours per week? ❑ Yes ❑ No

	FIRST NAME	INIT	LAST NAME	RELATIONSHIP
BENEFICIARY				

COVERAGE REQUESTED

Life/AD&D Amount: ____,000

Disability Amount: _____ /Wk.

MEDICAL: ❑ Single
❑ Emp. & Spouse
❑ Emp. & Children
❑ Family
❑ None

DENTAL: ❑ Single
❑ Emp. & Spouse*
❑ Emp. & Children*
❑ Family
❑ None

*Available only to groups issued after 3-31-91.

DEPENDENT CHILDREN TO BE COVERED:

	(First) NAME (Last)	BIRTHDATE
1.		– –
2.		– –
3.		– –
4.		– –
5.		– –
6.		– –

HAVE YOU EVER BEEN DECLINED, POSTPONED, RATED OR CHARGED AN EXTRA PREMIUM FOR LIFE, DISABILITY, OR HEALTH INSURANCE? If yes, give details:	❑ Yes ❑ No
HAVE YOU OR YOUR SPOUSE (IF TO BE INSURED) SMOKED CIGARETTES OR USED TOBACCO IN ANY FORM IN THE PAST YEAR?	❑ Yes ❑ No
HAVE YOU OR ANY DEPENDENTS TO BE INSURED, EVER APPLIED FOR, OR BEEN ISSUED ANY COVERAGE WITH FORTIS INSURANCE COMPANY? Specify date and Policy #:	❑ Yes ❑ No
DO YOU, OR ELIGIBLE DEPENDENTS TO BE INSURED, HAVE ANY HEALTH INSURANCE CURRENTLY IN FORCE? INDICATE COMPANY NAME, TYPE OF PLAN (GROUP OR INDIVIDUAL), POLICY NUMBER AND EFFECTIVE DATE OF COVERAGE: ______________	❑ Yes ❑ No
IF YES, WILL COVERAGE BE TERMINATED IF THIS PLAN IS ISSUED? ❑ Yes ❑ No	

EVIDENCE OF INSURABILITY

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

SECTION A: To be completed by *all* applicants

Within the last 10 years, has any person to be insured:

1. Been diagnosed as having or treated for:
   - a. cancer or malignancy? . . . . ❑ Yes ❑ No
   - b. heart disorder, heart disease or stroke?. . . . . ❑ Yes ❑ No
   - c. acquired immune deficiency syndrome (AIDS) or AIDS related Complex (ARC)?. . . . . ❑ Yes ❑ No
   - d. mental, nervous (including cerebral palsy and multiple sclerosis), or psychological disorder? . . . ❑ Yes ❑ No
2. Been a member of Alcoholics Anonymous or had any treatment for alcoholism or alcohol abuse or has such treatment sever been recommended by a physician? . . . . ❑ Yes ❑ No
3. Used sedatives, tranquilizers, cocaine or other hallucinogenic or narcotic drugs or received treatment for drug abuse or chemical dependency? . . . . ❑ Yes ❑ No
4. Been seen or treated by a physician or taken any medication within the past two years?. . . . . ❑ Yes ❑ No

Employee's	Spouse's (if applicable)
Height ______ Weight ______	Height ______ Weight ______

IMPORTANT!!

Provide complete details to all questions which have been answered YES. Include dates of, reasons for, and results of treatment, name of medication(s) taken and physician's name. Include dependent's name if applicable.

SECTION B: To be completed if Group has less than *20* medical certificates.

Within the last 10 years, has any person to be insured:

5. Been diagnosed as having or treated for:
   - a. diabetes, gout or hypertension?. . . . . ❑ Yes ❑ No
   - b. asthma, emphysema or respiratory disorder? . . . ❑ Yes ❑ No
   - c. arthritis or a back problem? . . . . ❑ Yes ❑ No
   - d. ulcer or digestive disorder? . . . . ❑ Yes ❑ No
   - e. genito (including breast) or urinary disorder?. . . . ❑ Yes ❑ No
   - f. epilepsy, convulsion or paralysis?. . . . . ❑ Yes ❑ No
   - g. eye or ear disorder? . . . . ❑ Yes ❑ No
6. Are you or any of your dependents currently pregnant? (supply delivery date) . . . . ❑ Yes ❑ No
7. Been confined to a hospital or similar institution within the past 5 years?. . . . . ❑ Yes ❑ No

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WAIVER OF COVERAGE (Complete only if waiving Medical or Dental coverage).
If waiving spouse and/or dependent children complete waiver of coverage.

After consideration, it is my decision not to enroll:

_______________ in the Medical Insurance Program.
_______________ my children and/or spouse in the Medical Plan.
_______________ in the Dental Coverage.
_______________ my children and/or spouse in the Dental Plan

Because:

_______________ I and/or my spouse and/or my children are covered under another Individual, Group, Prepaid, Government or State Medical/Dental Plan.
_______________ Other. Explain ______________________________
____

As a result, I waive all claim to benefits payable thereunder for myself and/or my dependents. I understand that in order for me and/or my dependents to be covered under this plan in the future, full evidence of insurability may be required, and some favorable provisions of the coverage applicable now may not apply at that time.

I hereby authorize my employer to deduct from my earnings the proper deductions, if any, as contributions towards the cost of this insurance. I am employed by the employer listed and regularly work at least 30 hours per week. I request insurance coverage under the group policy(ies) issued by Fortis Insurance Company. I hereby authorize any of the following to give to Fortis Insurance Company any information regarding me or my family as to employment, other insurance coverage, personal information, and medical care, advice or treatment: licensed physician; medical practitioner; hospital; clinic; any medical or medically related facility; insurance company; employer; or consumer reporting agency.

I understand that this information will be used by Fortis Insurance Company to determine my (our) eligibility for insurance, and disclosure of any health condition(s) does not preclude applicable pre-existing condition restrictions.

I represent that all statements and answers to the above questions are complete and true to the best of my knowledge and belief. I apply for insurance to be issued solely in reliance upon this application. I understand that the insurance contains a two year contestability period in the event of material misrepresentation and that any fraudulent statement or material misrepresentation on the application may result in loss of coverage under the policy, subject to the time limit on certain defenses provision and any legal proceedings.

If no longer employed, but on continuation, enter employment termination date ______________________________

Applicant's Signature ____ Dated at: ___________________ Date: ___________________