National Group Health Alliance LLC

"Quality, Complete, Affordable, Long Term"

EMPLOYEE UNIVERSAL HEALTH APPLICATION FOR ERISA EMPLOYER SPONSORED HEALTH PLAN

Employer Information

Name of Employer	Effective Date:	Group ID:	
Address:	City:	State:	Zip Code:

Employee Information

Full Name of Employee *last, first, middle*			Date of birth	Social Security Number		Gender
Mailing Address:			City:		State:	Zip Code:
Full Time Employment Date	Hours Worked Per Week	Occupation	Marital Status:	Email:		Daytime Phone:

Health Coverage Type (Enrolling or Waiving) Please select one of the following

You are requesting to be enrolled in this group health plan as:

☐ Employee Only ☐ Employee and Spouse ☐ Employee and Child(ren) ☐ Employee and Family

☐ Decline Employer Sponsored Benefits

Reason for Declining: ☐ Spouse's Employer's plan ☐ Individual Medical Plan ☐ VA Health Benefits

☐ Medicare Plan ☐ Medicaid Plan ☐ COBRA From Another Employer ☐ No Other Coverage

Enrolling Dependent Information *Must be completed for **EACH** dependent spouse or child to be enrolled*

First Name Last Name	Relationship	Date of Birth	Gender	Social Security Number	Height	Weight

Current Coverage or Prior Coverage Information

Do you, or any dependents to be covered have other health insurance that will continue after the eff date of this employer sponsored plan? Yes ☐ No ☐

Name of Carrier	Type of Coverage *"Medicare, Group, Individual or Other"*	Policy Holder's Name	Effective Date
List all covered individuals in the above plan:			If Medicare please select all that apply Medicare: ☐ A ☐ B ☐ C ☐ D

Waiving Dependent(s) Notice

If you have dependents (spouse and/or children) and you have selected to waive their coverage in your employer sponsored benefit plan, please sign below.

I understand I have the right to enroll my dependents at this time. I am voluntarily declining to enroll my dependents and have not been encouraged or pressured by anyone to decline such coverage. I understand that if I do not enroll my dependents at this time, and they do not have other qualifying coverage, their right to enroll in the future may be restricted, with a delayed effective date.

Employee Signature: _____ Date: _____

HEALTH STATEMENT

Employee

Height	Weight	Tobacco Use
		☐Yes ☐No

All questions must be answered and answers to each medical condition need to be complete and accurate to the best of the applicant's knowledge as of the date this application is electronically signed. The information provided in this section of the application will be used for setting rates prior to the final effective date of coverage.

EACH QUESTION MUST BE CHECKED "YES" OR "NO"

1. **Are you or anyone enrolling for coverage currently disabled, or are unable to perform any normal activities of daily living or self care?** ☐Yes ☐No **If yes, please provide details in the additional medical information section.**

2. **Within the last 5 years, have you or any dependent enrolling for coverage received or been scheduled to have treatment and/or medication(s) for, consulted with a physician or any other medical professional, or had medical testing performed for any disorders or of the following conditions?**

a. High Blood Pressure	☐ Yes	☐ No	f. Acid Reflux	☐ Yes	☐ No
b. High Cholesterol	☐ Yes	☐ No	g. Asthma	☐ Yes	☐ No
c. Depression	☐ Yes	☐ No	h. Allergies	☐ Yes	☐ No
d. Anxiety	☐ Yes	☐ No	i. Diabetes or Pre-diabetes	☐ Yes	☐ No
e. Sleep Apnea	☐ Yes	☐ No			

3. **Within the last 5 years, have you or any dependent enrolling for coverage received or been scheduled to have treatment and/or medication(s) for, consulted with a physician or any other medical professional, or had medical testing performed for any disorders or of the following?**

	Yes	No
a. Cancer, tumor, Leukemia, hodgkins disease, skin cancer-------	☐	☐
b. Stroke----------	☐	☐
c. Heart disorders such as Heart Murmur, Mitral Valve Prolapse, Arrhythmia----------	☐	☐
d. Heart attack, bypass, angioplasty, heart catherization, congestive heart failure, or any other disorders of the heart (other than high blood pressure) ----------	☐	☐
e. AIDS related complex, AIDS or HIV ----------	☐	☐
f. Autoimmune disorder, connective tissue disorder, lupus, Psoriasis or other Systemic disorders ----------	☐	☐
g. Blood disorder, Anemia, Hemophilia or other blood clotting disorder ----------	☐	☐
h. Blood clot, narrowing arteries (atherosclerosis, coronary artery disease) ----------	☐	☐
i. Back Pain or Neck pain resulting in pain management, medication or therapy, past or possible future surgery ----------	☐	☐

	Yes	No
j. Neurological disorders such as Multiple Sclerosis, Paralysis, Seizures, pituitary lesion etc. ----------	☐	☐
k. Mental nervous condition, insomnia, narcolepsy, bipolar, alcohol abuse etc. (other than depression or anxiety) ----------	☐	☐
l. Arthritis, (Rheumatoid Arthritis, Osteoarthritis, Psoriatic, other) disease of the muscles, joint disorders----------	☐	☐
m. Kidney stones, renal failure, hepatitis, cirrhosis or other disease of the liver, prostate, bladder or pancreas----------	☐	☐
n. Recreational drug abuse or prescription drug abuse ----------	☐	☐
o. Digestive disorder includes colon, intestinal, stomach, esophageal ----------	☐	☐
p. Congenital disorder, growth disorder or hormone disorder ---	☐	☐
q. Infertility treatment, male or female reproductive disorders ---	☐	☐
r. Respiratory disorder (other than asthma), any disease or disorder of the lungs, COPD, emphysema ----------	☐	☐

4. **Have you or any dependent(s) applying for coverage been;**
   a. **Hospitalized, had surgery, or had more than $5,000 in medical claims in the last 12 months?** ☐ Yes ☐ No
   b. **Advised that hospitalization or surgery will be necessary in the next 12 months?** ☐ Yes ☐ No

5. **Have you or any dependent(s) applying for coverage;**
   a. **Received an organ transplant or has a possible future transplant been discussed with a medical professional?** Yes ☐ No ☐

6. **Are you or any dependent(s) included in this enrollment currently pregnant?** ☐ Yes ☐ No

Member: First, Last Name	Due Date	Type of Delivery Anticipated Normal or Cesarean	Any Known Possible Complications? If Yes, please Explain

7. **Within the past 5 years, excluding any routine or preventative health care, has any person applying for coverage received any testing for or have diagnosed with, had treatment recommended or received treatment, including any prescription medications, or been hospitalized for any illness, health condition or injury that has not been indicated above?** Yes ☐ No ☐

ADDITIONAL MEDICAL INFORMATION

Question 1.i

Name	Last blood sugar reading and date		Last Hemoglobin A1C reading and date it was taken		Type of Diabetes	Controlled by; Diet, Oral Medication or Insulin Dependent

Question Number:	Member: First Name Last Name	Medical Condition	Provide diagnosis and treatment received	Treatment Dates		Remaining Symptoms
				Start	End	

Prescription Medications **List all medications, including self injectable medications taken in the last 12 months**

Member: First Name Last Name	Medical Condition	Brand Name OR Generic	Name	Dosage	Frequency	Still Taking Yes or No	Treating Physician Name and Phone Number
		☐ Brand ☐ Generic					
		☐ Brand ☐ Generic					
		☐ Brand ☐ Generic					
		☐ Brand ☐ Generic					
		☐ Brand ☐ Generic					

I affirm the answers in this "Universal Group Application" are complete and correct. I am providing these answers as part of the application procedure required by this insurance carrier to enroll in its insurance coverage. I understand that the insurance carrier will rely on each answer in making its determination to extend coverage and to determine the type of coverage offered. I understand if I have made any misstatement or omission in this application, the insurance carrier may take any action available by law, including but not limited to, retroactive adjustment of premiums or adjustment of claims. Further, I understand that any fraud or intentional misrepresentation of material fact on the part of the employer is cause investigation by the insurance carrier and/or other action available by law. I will promptly inform the insurance carrier in writing if anything happens before my coverage takes effect that makes an answer on this application incomplete or incorrect. Following receipt of a fully-executed application, coverage will be in force as of the effective date determined by the insurance carrier under applicable law

Employee Signature _____ Date: _____