VERNON PUBLIC SCHOOLS

30 Park Street • P.O. Box 600
Vernon, CT 06066-0600
Tel: 860-870-6000

This year's open enrollment period will be held Monday, May 23rd through Friday, June 17, 2011. Corporate Benefit Consultants and insurance representatives will be available to discuss the plans with you and to answer any questions you may have. The meeting times and locations are:

Tuesday May 24th 2:30-4:30pm Vernon Center Middle School Library
Wednesday June 1st 3:00-4:30pm Center Road School Library
Wednesday June 8th 2:30-4:30pm Central Administration - 2nd Floor Conf Room

The Open Enrollment forms and CIGNA information will be available on the Vernon Public Schools website or contact the Betty King. To access the forms and CIGNA information:

- Go to **www.vernonschools.com**
- Choose **"Departments"** from the menu on the left side and then "**Insurance and Benefits**" from the list of Office/Departments. Summary plan descriptions are available here as well.
- Select the folder for your bargaining unit

CHECK LIST:

- **Everyone** must complete the Employee Benefit Selection Form
- The following forms need to be completed if you are changing your election:

  Pre-Tax Cost Sharing
  CIGNA medical insurance enrollment
  Anthem dental insurance enrollment

- **Complete CIGNA Life insurance enrollment form only** if you wish to change beneficiaries.

Coverage will be effective July 1, 2011. For active employees, medical and dental cost share deductions will begin October 2011 and continue through June 2012 in eighteen (18) equal installments. Bills for retirees will be mailed to you once your open enrollment forms are received in the business office.

Please contact Betty King (860/870-6000 x-128) with questions about Open Enrollment.

Complete, sign, date and return your Open Enrollment forms to Betty King by June 17th, 2011.

VERNON PUBLIC SCHOOLS
EMPLOYEE BENEFIT PACKAGE SELECTION FORM
** VEA – TEACHERS **

I hereby elect to enroll in the following plans:

INSURANCE BENEFIT SELECTION COVERAGE OPTIONS		ENROLLMENT CHOICES
LIFE INSURANCE	GROUP TERM LIFE INSURANCE ($50,000)	**Board Provided No Action Necessary**
	VOLUNTARY LIFE INSURANCE I am electing to purchase	Indicate the Amount you are purchasing in increments of $10,000 $________________________
HEALTH & DENTAL CHOICES	I elect CASH IN LIEU OF HEALTH INSURANCE	Circle one: YES NO
	CIGNA OAP	Circle one: Individual or 2-person or Family
	HEALTH SPENDING ACCOUNT (H.S.A.)	Circle one: Individual or 2-person or Family **<u>Bi-weekly</u>** Voluntary H.S.A. Contribution $__________(can change contributions during the year)
	CO-PAY BASIC DENTAL W/ RIDERS ABC	Circle one: Individual or 2-person or Family
PRE-TAX	**PRE-TAX COST SHARING -**Premium Conversion	Circle one: YES NO

Should you desire to change your Employee Benefit Package during the year by adding/reducing coverage or waiving your right to health insurance coverage and electing to receive cash payments, these changes will take effect within sixty (60) days after the Business Office is notified in writing. Some changes can be retroactive (such as the birth of a child) & your cost sharing would be adjusted accordingly. **THIS FORM MUST BE SIGNED & RETURNED TO BETTY KING.**

______________________________ Employee Name (printed)

______________________________ Employee Social Security Number

______________________________ Employee Signature

______________________________ Date

05/23/2011 (new)

VERNON BOARD OF EDUCATION
PRE-TAX COST SHARING (Premium Conversion)
Enrollment Agreement

The Vernon Board of Education participates in a pre-tax cost sharing plan under Section 125 of the Internal Revenue Code. Under this plan, the portion of your income that will be used to pay for your share of your medical benefits (otherwise known as your cost sharing amount) will be deducted from your gross pay. If you elect to participate, your contribution towards your **medical insurance** is treated as pre-tax income and therefore not subject to income tax, social security or Medicare tax.

Please make your election below, sign and return the form to Betty King, Vernon Board of Education.

NAME: ______________________________________

SOCIAL SECURITY NUMBER: ____________________

_______I elect to make my contributions towards my **medical coverage** under the Vernon Board of Education Pre-Tax Cost Sharing Plan (Premium Conversion).

______I prefer to make my **medical coverage** contributions on an after tax basis.

I and the Vernon Board of Education, agree that my pay will be reduced by the amount of my required contribution for the benefit option (s) I have elected under the Pre-Tax Cost Sharing Plan (Premium Conversion

I understand that I cannot change or revoke this benefit election or salary reduction agreement as of any date prior to the next enrollment period unless I have a change in family status (i.e., marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse) or other event for which a change or revocation of an election is permitted.

Employee's Signature ___________________________ Date _____________________

Accepted and agreed to by the Vernon Board of Education ______________________

MEDICAL INSURANCE

Teachers

Please choose between the medical plans offered below. The summary plan descriptions are available on the Vernon Public Schools website or by request from Betty King.

CIGNA $20 OAP PLAN AND MEDCO DRUG PLAN $10/$25/$40

	Single	2 Person	Family
Monthly Rate for Cigna	$ 528.49	$ 1,056.91	$ 1,426.83
Monthly Rate for Medco	$ 120.25	$ 264.53	$ 336.69
Total Monthly Rate	$ 648.74	$ 1,321.44	$ 1,763.52
Total Annual Cost	$ 7,784.88	$ 15,857.28	$ 21,162.24
Employee cost share %	16%	16%	16%
Total Employee cost per year limited to 10/11 amount	$ 1,225.26	$ 2,496.42	$ 3,330.90
Employee payroll deduction 18 pays October through June	$ 68.07	$ 138.69	$ 185.05

CIGNA H.S.A. PLAN $2000/$4000 with Rx co-pay $7/$15/$35 after deductible

	Single	2 Person	Family
Monthly Rate for Cigna	$ 375.76	$ 751.52	$ 1,003.64
Total Annual Cost	$ 4,509.12	$ 9,018.24	$ 12,043.68
Employee cost share %	12%	12%	12%
Total Employee cost per year	$ 541.09	$ 1,082.19	$ 1,445.24
Employee payroll deduction 18 pays October through June	$ 30.06	$ 60.12	$ 80.29
Board annual contribution to the employee's H.S.A. account	$ 1,000.00	$ 2,000.00	$ 2,000.00

Employees may contribute to their H.S.A. account through payroll deductions and the amount can be changed during the year. The maximum contribution between Board and employee is $3,050 for single and $6,150 for 2 person or family coverage. The H.S.A. has been changed to a plan year (from calendar year) so the deductibles will cover the period July to June. If this is the first year you participate in the H.S.A. then the maximum contribution is prorated to half the above amounts. An additional $1,000 over age 55 catch-up contribution may be available. The limits for 2012 are $3,100 for single and $6,250 for 2 person or family coverage.

If you participate in the flexible spending accounts “Benny” Card program then the Benny card becomes a limited account as eligible expenses can not be applicable to both programs. Please contact us to review those changes and any implications to your benefits.

Enrollment / Change Form

Employer: Complete SHADED sections
Employee: Complete NON-SHADED sections

Insured and/or Administered by
Connecticut General Life Insurance Company
CIGNA HealthCare

A	☐ New Enroll ☐ Change ☐ Termination	Effective Date	Employer Name Vernon Public Schools	Employer Address PO Box 600, 30 Park Street, Vernon, CT 06066	
	Account Number 3333373	Branch Code		Medical Benefit Option Code	Vision Benefit Option Code VIS1

B	Employee Name *(last)*	*(first)*	*(M.I.)*	Social Security Number
	Employee Date of Birth *(MM/DD/YYYY)*	Home Phone	Work Phone	Home E-Mail Address (optional)
	Address *(Street)*	*(City)*	*(State)*	*(Zip Code)*

Last Name First Name M.I.	Date of Birth	Gender	Coverage Selection		Social Security Number (required)
Employee SAME AS ABOVE	SAME AS ABOVE	☐ M ☐ F	☐ Medical		SAME AS ABOVE
Spouse (whom you wish to cover)	| |	☐ M ☐ F	☐ Medical		
Dependent (whom you wish to cover)	| |	☐ M ☐ F	☐ Medical		
Dependent (whom you wish to cover)	| |	☐ M ☐ F	☐ Medical		
Dependent (whom you wish to cover)	| |	☐ M ☐ F	☐ Medical		

C Plan Options ☐ Open Access Plus Plan (OAP) $20 Copay Plan ☐ HSA Plan Teachers HSA Voluntary Contribution $__________
18 pays Oct-June (changes to contributions can be made during the year)

D Other Health Care Coverage
Do you or your dependents have other health insurance under a group plan, HMO or Medicare? ☐ Yes ☐ No If yes, please provide the following:

Name of person covered	Social Security or Medicare No.	Effective Date	Medicare Part A	Medicare Part B	Medicaid	Insurance Carrier
1.			☐	☐	☐	☐

CIGNA HealthCare Provisions

- "CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.
- I agree, for myself and my dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person to fully inform the healthplan and will execute such assignments, liens or other documents which may be necessary to enable the healthplan to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by the healthplans I will immediately reimburse the healthplan to the extent of services provided to the extent permitted by state law.

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading information concerning any material fact thereto commits a fraudulent insurance act.

AUTHORIZATION TO DEDUCT CONTRIBUTIONS

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.

SPECIAL PROVISION FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does not waive any terms of its contract. Further, by allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does not thereby express any opinion regarding the appropriateness of the change under Section 125 of the Internal Revenue Code or the terms of the employer's Section 125 plan.

	Signature – The information provided above is true and correct to the best of my knowledge, and I accept the provisions above which I have read and understand.	
E	Employee's Signature/ Date	Employer's Signature / Date

TEA

DENTAL INSURANCE - ANTHEM

Teachers

May elect co-pay basic dental with riders ABC
Dependents are covered to age 19

Co-Pay Basic Dental with riders ABC

	Single	2 Person	Family
Monthly Rate For basic dental	$ 20.80	$ 58.26	$ 70.74
Monthly Rate for riders ABC	$ 14.57	$ 40.79	$ 49.52
Total Monthly Rate	$ 35.37	$ 99.05	$ 120.26
Totat Annual Cost	$ 424.44	$ 1,188.60	$ 1,443.12
Employee cost share %	35%	35%	35%
Total Employee cost per year	$ 148.55	$ 416.01	$ 505.09
Employee payroll deduction 18 pays October through June	$ 8.25	$ 23.11	$ 28.06

In Connecticut, Anthem Blue Cross and Blue Shield is a trade name of Anthem Health Plans, Inc., an independent licensee of the Blue Cross and Blue Shield Association. ® Registered marks of the Blue Cross and Blue Shield Association.

Enrollment and Membership Change Form

1. Tell Us About You

Current Anthem BCBS Contract Number, if any

Last Name | First Name | M.I.

Home Address: Number and Street or P.O. Box | Apt. #

City | State | Zip Code

Home Telephone ( ) | Work Telephone ( )

MARITAL STATUS: ☐ Single ☐ Legally Separated ☐ Widowed ☐ Married ☐ Separated ☐ Divorced

2. New Membership

☐ NEW HIRE
☐ OPEN ENROLLMENT
☐ COBRA/C.G.S. 38a-538
DATE OF QUALIFYING EVENT ___/___/___
REASON ______ SEE INSTRUCTION SHEET
☐ NEW GROUP (ORIG ENROLLMENT)

3. Change Membership

CHANGE:
☐ ADDRESS
☐ NAME
☐ OTHER
REASON ______
DATE ___/___/___

To Be Completed By Employer

Requested Effective Date ___/___/___

Firm Division No. 005241-

Health Benefit Plan

For Office Use Only

4. Your Membership Choices

	Individual	Two Person	Family
☐ DENTAL	☐	☐	☐

Includes riders ABC

Are you or any other eligible dependent listed on this form currently confined to a hospital or other healthcare facility, totally disabled or physically impaired? ☐ YES ☐ NO

5. Where You Work

COMPANY NAME

VERNON PUBLIC SCHOOLS

ARE YOU ACTIVELY AT WORK? ☐ YES ☐ NO / (IF NO) REASON ☐ SICK ☐ INJURED ☐ OTHER

ARE YOU CURRENTLY CLAIMING WORKERS' COMP. MEDICAL BENEFITS? ☐ YES ☐ NO

DO YOU WORK 30 OR MORE HOURS PER WEEK? ☐ YES ☐ NO

DATE OF FULL TIME HIRE	DATE OF PART TIME HIRE	DATE OF REHIRE
/ /	/ /	/ /

6. List Members To Be Added/Cancelled

SEX	NAME (FIRST/MIDDLE/LAST NAME)	Add	Cancel	Social Security Number	Date of Birth (MM/DD/YYYY)	Full Time Student Age 19 or Over	BELOW PLEASE INDICATE NAME OF RECOGNIZED INSTITUTION FOR FULL TIME STUDENTS	Primary Care Physician (PCP) Name (Refer to Provider Directory or www.anthem.com) Check ☑ the box if you currently use this physician.
☐M ☐F	Self				/ /	(Circle Yes or No)		Name / City / PCP Provider No. ☐
☐M ☐F	Spouse				/ /			Name / City / PCP Provider No. ☐
DEPENDENTS: Children over 19 may be eligible if disabled, or unmarried full-time students. Please circle disabled dependent.								
☐M ☐F	Dependent				/ /	Y N		Name / City / PCP Provider No. ☐
☐M ☐F	Dependent				/ /	Y N		Name / City / PCP Provider No. ☐
☐M ☐F	Dependent				/ /	Y N		Name / City / PCP Provider No. ☐

7. Tell Us About Your Other Insurance

Do you or any other member of your family have any other medical, dental, or Anthem BCBS coverage? ☐ YES ☐ NO

If yes, please fill in the information below. ☐ Self ☐ Spouse ☐ Children

Name of Other Insurance Company	Name of Subscriber (Policyholder)	Policy or ID No.	Reason For Termination	First and Last Date of Coverage

8. Medicare/Medicaid

Do you or any covered member have Medicare/Medicaid coverage? ☐ YES ☐ NO

Have you or any covered member applied for Medicare/Medicaid disability? ☐ YES ☐ NO

Name (Self)	Are you actively at work?	Retirement Date	Name (Dependent)	Is this person actively at work?	Retirement Date
	☐ YES ☐ NO	/ /		☐ YES ☐ NO	/ /

Medicare No.	Effective Dates: Medicare A (Hospital)	Medicare B (Medical)	Medicare No.	Effective Dates: Medicare A (Hospital)	Medicare B (Medical)
	/ /	/ /		/ /	/ /

I understand that false and/or incomplete responses or statements may result in rescission of coverage and/or non-payment of claims for myself or my eligible dependents. I understand a copy of this application is provided to me as part of my Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein. I certify that my statements in this form are true and complete to the best of my knowledge and belief.

9. Employee Signature

Date ___/___/___

tea

LIFE INSURANCE - CIGNA

Teachers

The Board pays life insurance for eligible active employees per Union contracts. The rate is $0.245 per $1,000 in coverage. Retirees may continue basic life insurance at their cost.

The amount of life insurance is: $50,000

You only need to fill out the Basic and Voluntary Life Enrollment form if you are changing the beneficiary or electing voluntary coverage.

VOLUNTARY LIFE INSURANCE

Voluntary life coverage must be purchased in multiples of $10,000. Employees may elect coverage to a maximum of $100,000.

Not available to retirees.

This year we have switched to Cigna and they are offering open enrollment for the Voluntary Life insurance. This means that all employees have the opportunity to elect coverage for the first time or increase their voluntary life coverage with CIGNA up to the Guarantee Issue amount of $100,000, without completing the Evidence of Insurability Form. All elections of coverage up to $100,000 will be automatically approved. ALL current Voluntary Life Benefit Amounts already in place with Anthem will be Grandfathered by CIGNA.

You must fill out the Basic and Voluntary Life Enrollment form if you are electing any voluntary life coverage and if applicable the Evidence of Insurability form.

Rates for voluntary life insurance per $1,000 of coverage:

Age		Rate
age to 29 years	$	0.06
age 30-34	$	0.07
age 35-39	$	0.09
age 40-44	$	0.15
age 45-49	$	0.25
age 50-54	$	0.41
age 55-59	$	0.63
age 60-64	$	0.96
age 65-69	$	1.47
age 70 & up	$	2.23

CIGNA **Vernon Public Schools**

BENEFIT ENROLLMENT FORM
BASIC & VOLUNTARY LIFE, ACCIDENT & DISABILITY INSURANCE

EMPLOYEE NAME (Last, First): ______ HIRE DATE: ______ BENEFIT EFF. DATE:

EMPLOYEE INFORMATION

EMPLOYEE NAME:	DIVISION: VERNON PUBLIC SCHOOLS		DATE OF HIRE / /	DATE OF BIRTH: / /
ADDRESS:	HOME PHONE:	WORK PHONE:		SEX: ☐ Male ☐ Female
CITY, STATE, ZIP	SOCIAL SECURITY NUMBER:		MARITAL STATUS: ☐ Single ☐ Married	

BASIC LIFE/AD&D, VOLUNTARY LIFE & LTD

BASIC LIFE & ACCIDENT INSURANCE:
☐ Life
☐ AD&D

VOLUNTARY LIFE INSURANCE: (Employee Paid)

Units of $10,000
Coverage Amount: $__________________

BENEFICIARY DESIGNATION: Unless you designate a percentage, proceeds are paid to primary surviving beneficiaries in equal shares. If you designate contingent beneficiaries and do not designate percentages, proceeds are paid to the surviving contingent beneficiaries in equal shares. Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).

Basic & Voluntary Life Insurance, Life Insurance Company of North America – Policy No. FLX 964103

Primary Beneficiary (ies):	Relationship	SSN	Date of Birth	Total must =100%
Contingent (ies):	Relationship	SSN	Date of Birth	Total must =100%

Basic Accident Insurance, Life Insurance Company of North America – Policy No. OK 965722

Primary Beneficiary (ies):	Relationship	SSN	Date of Birth	Total must =100%
Contingent (ies):	Relationship	SSN	Date of Birth	Total must =100%

Community Property Laws: If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary, it is possible that payment of benefits may be delayed or disputed unless your spouse also signs in beneficiary designation.

Spouse Signature: Date:

I accept the insurance coverages elected above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my earnings. If I have not elected coverage, I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability at my own expense and that coverage is subject to the insurance company's approval.

EMPLOYEE SIGNATURE: **DATE:**

Vea/vsna

EVIDENCE OF INSURABILITY FORM

Life Insurance Company of North America (LINA)
a CIGNA Company (herein called the Insurance Company)
For info and customer service call 1-800-732-1603.

- *The applicant must sign and date this form.*
- *This form cannot be considered unless received within 30 days of the date it is dated.*

Important: *Please enter all dates in mm/dd/yyyy format . Please print (preferably in black ink)*

EMPLOYER USE (MANDATORY DATA NEEDED): In order to process this application, the employer must complete this information.

EMPLOYER Vernon Public Schools **Policy** FLX-964103

CLASS ______ **LOCATION/PAYCODE #** ______ **DATE OF HIRE** ______ **ANNUAL SALARY** ______ **VERIFIED BY** ______

REASON FOR REQUEST: ☐ **NEW HIRE** ☐ **INITIAL ENROLLMENT EVENT** ☐ **ONGOING ENROLLMENT EVENT** ☐ **LATE ENTRANT**

	VOLUNTARY EMPLOYEE
NEW COVERAGE (TOTAL)	
CURRENT COVERAGE	
GUARANTEED COVERAGE PORTION OF REQUESTED INCREASE	
AMOUNT SUBJECT TO MEDICAL EVIDENCE	

EMPLOYEE SECTION

Employee Name ______ Social Security # ______ Birthdate ______
Address ______ City ______ State ______ Zip ______
Work Phone ______ Home Phone ______ Employee ID # ______ Sex: ☐ M ☐ F
In order to confirm your election, please provide your signature: ______ Date ______

IMPORTANT
Please complete each section that follows if it is needed.
Read the Agreements and Authorization. Sign and date the form in the space provided.

Complete the employee information in this section if you (i.e., the Employee) are applying for Life Insurance that is greater than the guaranteed amount or are applying for Life Insurance more than 31 days after you were eligible for the insurance.

Height and Weight Information

Employee	
Height ft in	Weigh lbs

PHYSICIAN SECTION

Employee Physician Name ______ Phone No. ______
Street Address ______ City ______ State ______ Zip ______

Please indicate your answers for each question by checking the Yes or No box for the question.

SECTION A

Within the last 5 years has the proposed insured been:

- diagnosed with any of the conditions shown in items A through J below,
- told by a medical professional he/she has or may have any of the conditions shown in items A through J below,
- or been treated by a medical professional for any of the conditions shown in items A through J below?

		Employee Yes	Employee No
A.	High blood pressure, heart attack, chest pain or Angina, a heart murmur, poor circulation or any other condition affecting the heart or circulatory system?	☐	☐
B.	Diabetes, glandular condition, Hepatitis, or any condition affecting the esophagus, stomach, intestines, liver or pancreas?	☐	☐
C.	Asthma, Chronic Bronchitis, Emphysema, or any other condition affecting the lungs or respiratory tract?	☐	☐
D.	Any condition affecting the kidneys, urinary tract, prostate gland or reproductive system?	☐	☐
E.	HIV infection, AIDS, or any other condition affecting the immune system or lymph nodes?	☐	☐
F.	Stroke, Transient Ischemic Attack (TIA), Alzheimer's disease, paralysis, Epilepsy, fainting, seizures, headaches, or other condition affecting the nervous system?	☐	☐
G.	Anemia or any other condition affecting the blood, Lupus, Arthritis, deformity or loss of limb?	☐	☐
H.	Anxiety, Depression, Bipolar Disorder, or any other mental disorder or condition?	☐	☐
I.	Cancer, Tumor, Leukemia, Hodgkin's Disease, Polyps or Mole?	☐	☐
J.	Alcohol or drug abuse or dependency?	☐	☐

Fold and staple to conceal health questions. Return application to your employer. Be sure to make a copy for your own records.

Name ______________________________ Social Security # ____________________

SECTION B

Within the last 5 years has the proposed insured:

		Employee Yes	Employee No
A.	Had a Driving While Intoxicated (DWI), Driving Under the Influence (DUI) or Operating Under the Influence (OUI) conviction?	❑	❑
B.	Smoked cigarettes:	❑	❑
	1. For how many years has the proposed insured smoked?	______	
	2. Approximately how many cigarettes are, or were, smoked on average per day?	______	
	3. If cigarette smoking has been discontinued, when (month and year) did the proposed insured quit smoking?	______	
C.	Used any controlled or illegal drug or other substance?	❑	❑
D.	Been seen for, or been advised to have sought treatment for, observation and/or consultation for surgery, medical examination, and/or tests, such as blood, urine, X-rays, electrocardiograms, scans, biopsies, or any medical tests/exams not listed here or above, other than normal routine physical exams?	❑	❑
E.	Used any medication prescribed by a physician or other medical practitioner, or used any form of alternative and complementary medical treatment or remedy, including herbs or acupuncture?	❑	❑
F.	Been seen, sought treatment for, consulted, advised they had and/or received any medical advice from a health care practitioner for any disease, disorder and/or medical impairment not listed above?	❑	❑

Use the space below to explain "Yes" answers. If more space is needed, use a new page. Sign and date it. Attach it to this form.

Name of Employee	*Medical Condition*	*Date Occurred*	*Duration/Treatment Received*	*Current Status*

***Caution**: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.*

♦ ♦ ♦ AGREEMENTS AND AUTHORIZATION ♦ ♦ ♦

To the best of my knowledge and belief all written, telephonic and electronic info I gave is true and complete. I understand that my insurance will not go into effect unless I am actively at work on the effective date. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions. I understand and agree that:

(1) This request will be a part of the policy that provides the insurance.
(2) I may need to provide more medical info.
(3) I may need to take medical tests and report the results to the Insurance Company.
(4) I must report any change in my health that happens before the insurance is effective.
(5) Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.

Authorization. I permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, the Medical Information Bureau (MIB) or any other person or organization having info about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record, of me to disclose to the Insurance Company or its authorized agent, any such info, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization is valid for 30 months from the date below. I accept that a copy of this Authorization is as valid as the original.

I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request.

I understand that the info will be used to assess my request for insurance.

I may revoke this authorization at any time in writing. Any such revocation will not: (1) change any action taken in reliance on the Authorization; and (2) change the Insurance Company's right to use the Authorization for contest of a claim or policy in accordance with applicable law.

I understand that info provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (The Insurance Companies are subject to the Gramm-Leach-Bliley act and state privacy laws. They do not disclose protected information except as permitted by those laws.)

Sign Here ______________________ *Employee's Signature* ____________ *Month/Day/Year*

Notice: Personal information may be collected from persons other than those proposed for coverage. Information may be disclosed to third parties without your authorization as permitted by law. You have the right to access and correct all personal information collected. Additional information about the insurance company's privacy practices is available upon request.

Return to your employer. Be sure to make a copy for your own records.

TL-009320 (CT)
5/2011