Group Employee Application

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY®

Employer Name_____ Group # _____

Employee Name_____ Division/Location _____

A. EMPLOYEE PERSONAL INFORMATION

Home Address	City	State	Zip Code

Phone	Email	Marital Status ☐ Single ☐ Married	Occupation	Full-time Date of Hire / /	Average hours per week:

Wage/Salary $ per	How is income reported to IRS? ☐ W2 (Note: 1099 employees are not eligible) ☐ Other_____	Employee Status: ☐ Active ☐ Rehired ☐ Retired ☐ COBRA ☐ USERRA ____ /____/ ____ Qualifying date

If **COBRA**, date of qualifying event_____ /_____ /_____

Nature of event: ☐ Termination ☐ Retirement ☐ Divorce ☐ Reduction in hours ☐ No longer eligible ☐ Other _____

Reason for Enrollment: ☐ New Group ☐ New Hire ☐ Open Enrollment ☐ Change in coverage or status

B. EMPLOYEE AND DEPENDENT INFORMATION (List only those dependents applying for coverage)

Relationship	Name (First, MI, Last)	SSN:	Height	Weight	Sex	Birth Date	Full time student?	Home Office Use Pre-Ex
Employee					M F	/ /		
Spouse					M F	/ /		
Child					M F	/ /	☐ Yes* ☐ No	
Child					M F	/ /	☐ Yes* ☐ No	
Child					M F	/ /	☐ Yes* ☐ No	

*Children over age 19, list school and number of credit hours_____

C. COVERAGE SELECTIONS AND WAIVERS

Please indicate which eligible coverage(s) you are choosing:				
	Medical: ☐ Employee	☐ Employee/Spouse	☐ Employee/Child(ren)	☐ Employee/Spouse/Child(ren)
	Dental: ☐ Employee	☐ Employee/Spouse	☐ Employee/Child(ren)	☐ Employee/Spouse/Child(ren)
	Vision: ☐ Employee	☐ Employee/Spouse	☐ Employee/Child(ren)	☐ Employee/Spouse/Child(ren)

Deductible Option (if plan has more than one option) _____ Network Option (if plan has more than one option)_____

I certify that I was given the opportunity to apply for group benefits offered by my employer through American Community and I do not accept the offer.

I waive **Medical** coverage for:	☐ Myself and my dependents	☐ My spouse only	☐ My children only
I waive **Dental** coverage for:	☐ Myself and my dependents	☐ My spouse only	☐ My children only
I waive **Vision** coverage for:	☐ Myself and my dependents	☐ My spouse only	☐ My children only

I am declining coverage due to existence of other coverage: ☐ Spouse's Employer Plan ☐ Parent's Plan ☐ Individual Plan
☐ Medicare ☐ Medicaid ☐ COBRA from prior employer ☐ VA Eligibility ☐ Tri-Care ☐ Other _____
☐ I (we) have no other coverage at this time.

Home Office Use Only			
Endorsement	TA LE LOSS OPEN	LF/AD_____	Medical RX M/O
	CLAPP MEDS N/A		None S C P F
	DOH _____	Dependent Life	Dental
	Affiliation Period (MI) _____		None S C P F
Issue State_____	Waiting Period_____	WI_____	VS/EX only
	App Signed_____		None S C P F
Group #	Certificate #		Effective Date

D. OTHER COVERAGE SECTION

Previous Coverage: Within the last 18 months, did you have health insurance coverage? ☐ Yes ☐ No

If yes, who was covered? _____

_____

Insurance Company Name:_____

Phone# _____ Policy _____

Effective Date_____ End Date _____

Concurrent Coverage: Will you, your dependent or spouse keep other health coverage in addition to this coverage? ☐ Yes ☐ No

If yes, who is covered? _____

_____

Insurance Company Name:_____

Phone# _____ Policy _____

Effective Date_____

E. MEDICAL CONDITIONS (EXPLAIN ALL CHECKED CONDITIONS IN SECTION G)

For groups of fewer than 51 employees, this information will be used for rate setting purposes only. For groups of 51 or more employees, this information will be used to accept or decline the employer group and for rate setting purposes only. In no event will such information be used to decline coverage for you or any dependent as mandated by HIPAA or state law. **In the past five years have you, your spouse or any dependent listed been treated for, diagnosed, or been recommended for future surgery, diagnostic testing or medical treatment or received medical advice for any of the following conditions? If yes, please check condition and explain in section G.**

- ☐ Abnormal pap smear
- ☐ Autoimmune disease (other than AIDS/HIV)
- ☐ Allergies/Asthma
- ☐ Alcohol or drug problems
- ☐ Anemia or blood disorder
- ☐ Arthritis
- ☐ Attention deficit disorder
- ☐ Back, neck, spine disorder
- ☐ Blood, bleeding or clotting disorder
- ☐ Bone disorder
- ☐ Breast disorder
- ☐ Cancer
- ☐ Chest Pain
- ☐ Chronic fatigue disorder
- ☐ Diabetes
- ☐ Ear disorder
- ☐ Eating disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Eye Disorder
- ☐ Gallbladder disorder
- ☐ Genital disorder
- ☐ Headaches or migraines
- ☐ Heart/Circulatory problems
- ☐ Hepatitis
- ☐ Hernia
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Infertility
- ☐ Intestinal disorder
- ☐ Joint disorder (Knee, hip, wrist, ankle)
- ☐ Liver/pancreas disorder
- ☐ Lung disease
- ☐ Lupus
- ☐ Lymph node enlargement
- ☐ Menstrual disorder
- ☐ Mental disorder (including depression)
- ☐ Multiple sclerosis
- ☐ Muscle disorder
- ☐ Nervous system disorder
- ☐ Organ or other transplant
- ☐ Pregnancy complications
- ☐ Prostate disorder
- ☐ Rectal disorder
- ☐ Seizures
- ☐ Sexual dysfunction
- ☐ Sinus or nasal disorder
- ☐ Skin disorder
- ☐ Stomach disorder
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Tumor, cyst or polyp
- ☐ Ulcers
- ☐ Urinary/kidney/bladder disorder
- ☐ Vascular (blood vessel) disorder

Applicant: please initial here_____

F. MEDICAL QUESTIONS (EXPLAIN ALL YES ANSWERS IN SECTION G)

	Employee		Dependents	
1. Within the past five years, have you or your dependents been treated for or told you have any other condition/disorder/disease not listed above?	Yes	No	Yes	No
2. Are you an expectant parent or any of your dependents currently pregnant? Due date_____	Yes	No	Yes	No
3. Has anyone used tobacco products within the last 12 months?	Yes	No	Yes	No
4. Have you or your dependents been hospitalized, operated on or been advised to have an operation which has not yet been performed?	Yes	No	Yes	No
5. Are you or your dependents currently taking any medications or taken any medications in the past 12 months?	Yes	No	Yes	No
6. Within the past five years, have you or any of your dependents been diagnosed or received treatment for AIDS or HIV infection?	Yes	No	Yes	No

G. DETAILS (EXPLAIN ALL CHECKED CONDITIONS AND YES ANSWERS FROM SECTIONS E AND F)

Name	Condition	Dates of Treatment	Type of Treatment	Current Medications Name Dosage/Frequency

H. LIFE/AD&D BENEFICIARY DESIGNATION

Beneficiary _____ Relationship _____ SSN _____

I. EMPLOYEE AGREEMENT/CONSENT

Consent: I consent to any physician, hospital, clinic, pharmacy, other medical or medically related facility, insurance company, health information repository to give to American Community Mutual Insurance Company, its legal representatives or its reinsurers, any information, record or knowledge of the health of any persons proposed for insurance to carry out treatment, payment or health care operations. This consent includes information about drug and alcohol abuse and psychiatric conditions but does not provide for the release of psychotherapy notes. I consent to any consumer reporting agency that has any record, public record or knowledge of the character, general reputation, personal characteristics and mode of living, of any persons proposed for insurance to give to American Community Mutual Insurance Company, its legal representatives or its reinsurers any such record or knowledge for purposes of underwriting insurance. This consent does not allow a consumer reporting agency to release health information. A photographic copy of this consent shall be as valid as the original for 24 months from the date below. I know that I, or my authorized representative may request and am entitled to receive a copy of this consent.

I acknowledge that I have been provided with a Notice of Your Privacy Rights, which provides a complete description of how my protected health information may be used or disclosed.

Contribution: I am aware that I am required to contribute toward the cost of my insurance premium as indicated by my employer. I authorize my employer to deduct my portion of the premium for this insurance from my pay.

Disclosures: I understand no insurance exists unless and until my employer received notification in writing from American Community's Home Office indicating coverage for me and my dependents and the effective date. If, prior to such notification, anyone applying for coverage under this application consults a doctor, is hospitalized or has a change in health, I agree to inform American Community immediately. I understand that the agent does not have the authority to vary or waive any of the provisions of this application nor any provisions, terms or conditions of any other forms or materials supplied by American Community, nor bind American Community to any promise of coverage.

Representations

I represent that all statements and answers are true and complete to the best of my knowledge. I understand and agree that omissions, misrepresentation or misstatements may be used to deny a claim or terminate coverage if such information materially affects the degree of risk. **Any person who, with intent to defraud, submits an application or files a claim containing a false statement may be guilty of insurance fraud.**

J. SIGNATURE REQUIRED (THIS FORM MUST BE SIGNED AND DATED)

Signature of Key Applicant or personal representative	Relationship to applicant or representative's authority to act for applicant	Date	Signed at: City and State
Signature of Spouse	Relationship to applicant or representative's authority to act for applicant	Date	Signed at: City and State

NOTICES AND RIGHTS (For employee to keep. Please tear off.)

PRE-EXISTING CONDITION EXCLUSION

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 a six-month period. Generally, this six-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption. You can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. **To reduce the exclusion period by your creditable coverage, you must give us a copy of any certificates of creditable coverage you have.** If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage. All questions about the pre-existing condition exclusion and creditable coverage should be directed to a Customer Service Representative at 800-991-2642.

Arizona, Illinois and Ohio Residents: The pre-existing exclusion period may apply for up to 12 months (18 months for late entrants) after the coverage begins.

Indiana Residents: For groups of fewer than 51 employees, the pre-existing exclusion period may apply for up to 9 months (15 months for late entrants) after the coverage begins. For groups of 51 or more employees, the pre-existing exclusion period may apply for up to 12 months (18 months for late entrants) after the coverage begins.

Michigan Residents: For groups of fewer than 51 employees, the pre-existing exclusion period may apply for up to 12 months after the coverage begins. For groups of 51 or more employees, the pre-existing exclusion period may apply for up to 6 months after the coverage begins.

Missouri Residents: The pre-existing exclusion period may apply for up to 12 months after the coverage begins. For late enrollees, this exclusion period may apply for up to 12 months from your first day of coverage without any medical advice, diagnosis, care or treatment for a pre-existing condition or 18 months from your first day of coverage.

NOTICE OF SPECIAL ENROLLMENT

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, you must request enrollment within 31 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

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 dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

PRIVACY NOTICE

We know that your trust in us is very important. We're committed to protecting your privacy rights. Please read this notice carefully. It discloses your privacy rights.

Obtaining Information About You – We may obtain information from your application, a telephone interview with you, claims history with us, policies you have or had with us, account balances and premium payment history, and other sources, such as health care providers (medical information), and consumer reporting agencies (credit reports). Your address, birthday, telephone number, social security number are examples of such information. An investigative consumer report may be prepared where information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted to obtain information as to your character, general reputation and personal characteristics. You may have to share such information with us, our affiliates, agencies or others working with us.

Our Use of Personal Information – We will share such information only with companies associated with us. We, or your agent or broker, may use your information to offer you products or help you choose a product.

We may, as permitted by the law and without your prior approval, give information about you to persons who do business for us, your agent or broker, other insurance companies, or other persons handling your business, insurance company support organizations, regulatory or law enforcement authorities; and our affiliated companies. Information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.

Your Rights

- The right to access, inspect and copy the personal information pertaining to you that we maintain in our files about you.
- The right to request that we correct or amend any personal information that we have about you.
- To request an interview in connection with the preparation of an investigative consumer report.

To exercise these rights, please send a **written request to the attention of the Privacy Coordinator.**

Continued on Reverse

How We Protect Your Personal Information – We protect the information we share with companies working for us through an agreement. The agreement obligates those companies to keep your information confidential.

Only our employees who work to service your business see your personal information. We have trained our employees to closely follow our privacy rules for your protection. Your privacy rights will continue if you cease to be our customer.

THE REMAINDER OF THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required to maintain the privacy of your personal medical information and provide you with this notice as to our legal duties and privacy practices. We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice and to make any new provisions effective to all of the medical information that we maintain about you. If we revise this notice, we will provide you with a revised notice by mailing the revised notice to the address you have supplied us.

STATEMENT OF YOUR RIGHTS

You have the right to know how we use or disclose your personal medical information. There are certain uses and disclosures of your personal medical information that we are permitted or required to make by law without your permission. In addition, you have:

The right to request that we place additional restrictions on our uses and disclosures of your personal medical information, but we are not obligated to agree to any such restrictions.

The right to access, inspect and copy the protected information pertaining to you that we maintain in our files, and the right to request that we correct or amend any personal medical information that we have about you.

The right to receive an accounting of the disclosures of your personal medical information that we make for purposes other than activities related to your treatment, or our payment functions or other health care operations.

The right to request that you receive communications of personal medical information in a confidential manner.

The right to obtain a paper copy of this notice from us on request.

To exercise these rights please send a written request to the attention of the Privacy Coordinator.

PERMISSIBLE USES AND DISCLOSURES OF PROTECTED MEDICAL INFORMATION

Payment Functions. We may use or disclose your protected medical information without your permission to carry out activities relating to reimbursing you for the provision of health care, obtaining premiums, determining coverage, and providing benefits under the policy of insurance that you are purchasing. For example, payment functions may include (but are not limited to) reviewing health care services with respect to medical necessity, coverage under the policy, appropriateness of care, or justification of charges.

Health Care Operations. We may also use or disclose your protected medical information without your permission to carry out certain insurance-related activities. For example, these activities include using your protected information for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of another contract of health insurance, placing a contract for reinsurance of risk relating to claims for health care, and performing audit functions to ensure compliance and proper claims payment.

Group Health Plan. We may disclose your protected medical information to your employer as necessary for the purpose of reporting claims experience or conducting an audit if you are covered under an employer-based group health insurance plan.

Business Associates. We may disclose your protected medical information to our business associates. There are some services provided in our company through contracts with our business associates.

Uses Permitted By Law. We may also use or disclose your protected medical information without your written permission for purposes permitted or required by law.

Authorized Uses. All other disclosures of your protected medical information will be made only with your written permission, and any permission that you give us may be revoked by you at any time.

COMPLAINTS ABOUT MISUSE OF INFORMATION – If you believe your privacy rights have been violated you may complain either directly to us or to the Secretary of Health and Human Services (HHS). Please submit all complaints in writing or verbally to us or HHS as follows:

American Community Mutual Insurance Company
Attn: Privacy Officer
39201 Seven Mile Road
Livonia, MI 48152
1-800-991-2642

U.S. Department of Health and Human Services
Attn: Secretary
200 Independence Ave S.W.
Washington, DC 20201

You will not be retaliated against in any way for filing a complaint.

OBTAINING FURTHER INFORMATION

Please call us if you have any questions or comments. The phone number is 1-800-991-2642.

Effective Date: April 14, 2003