Please complete and sign both pages in their entirety if applying for medical coverage.

Health+

Health+ Group Health and Dental Application

❑ NEW HIRE ❑ LATE ENROLLEE ❑ WAIVER ❑ SPECIAL ENROLLEE		Effective Date / /	Plan Election

A. Enrollment Information

Name (First, Last, Middle Initial)	Social Security Number	Soc. Sec. Disabled? ❑Yes ❑No	Medicare Enrolled? ❑Yes ❑No	❑ Male ❑ Female	Birthdate	Height	Weight

Address (Include Street, Building Name/Number, Apartment Number, City, State, Zip Code)	County	Telephone ( )	Marital Status: ❑ Single ❑ Married

Employer Name and Address	Employment Type ❑ Salaried ❑ Hourly	Hire Date	Salary Amount $_____/year $_____/hour	Employment Status ❑ Full-Time ❑ Part-Time ❑ Retiree ❑ COBRA

B. Coverage Information: Please indicate which eligible coverage(s) you are choosing. Please check only one type of coverage per product.

Medical: ❑ Employee ❑ Employee/Spouse ❑ Employee/Child(ren) ❑ Employee/Spouse/Child(ren)
Dental: ❑ Employee ❑ Employee/Spouse ❑ Employee/Child(ren) ❑ Employee/Spouse/Child(ren) Dental:

Name (First, Last, Middle Initial) List all persons to be covered excluding applicant.	Birthdate	Social Security Number	Gender	Height	Weight	Full-Time Student?	Soc. Sec. Disabled?	Medicare Enrolled?
Spouse			❑ M ❑ F				❑ Yes ❑ No	❑ Yes ❑ No
Dependent			❑ M ❑ F			❑ Yes	❑ Yes ❑ No	❑ Yes ❑ No
Dependent			❑ M ❑ F			❑ Yes	❑ Yes ❑ No	❑ Yes ❑ No
Dependent			❑ M ❑ F			❑ Yes	❑ Yes ❑ No	❑ Yes ❑ No
Dependent			❑ M ❑ F			❑ Yes	❑ Yes ❑ No	❑ Yes ❑ No
Dependent			❑ M ❑ F			❑ Yes	❑ Yes ❑ No	❑ Yes ❑ No

C. Medicare Coverage

Name of covered person: Medicare ID (HIC) No.: Eligibility Date / Effective Date (Part A):
Eligibility Date / Effective Date (Part B):

D. Other Carrier Information

❑ Yes ❑ No Will you, your spouse or your dependents keep other health coverage in addition to this Health+ coverage?

If yes, please complete the following section.

Name (First, Last, Middle Initial)

Employer (if applicable)

Insurance Company/HMO Name and Address

Policy No.	Contract Type ❑ Single ❑ Family ❑ 2-Person	Effective Date

E. Prior Coverage Information

❑ Yes ❑ No New Hire: Did you, your spouse or dependents have coverage within 63 days prior to the hire date stated above?

❑ Yes ❑ No Special Enrollee/Late Enrollee: Did you, your spouse or dependents have health coverage within 63 days prior to the effective date of this coverage?

Complete the following section.

Name of Covered Person(s):

Employer (if applicable)

Insurance Company/HMO Name and Address

Policy Number	Contract Type ❑ Single ❑ Family ❑ 2-Person	Effective Date	End Date

F. Waiver (Please complete if you are declining _____Health coverage ____Dental coverage.)

❑ I decline coverage for me and all my dependents. Please check all that apply:

I (We) have other coverage through: __ spouse's employer __ parent/guardian's employer __ individual policy __ Medicare __ Medicaid __ Indian Health Service __ Tricare

❑ Other reason for declining coverage (please explain):

_____

Note: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your Dependent(s) in this plan if you or your dependent(s) lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependent(s)' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent(s) 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.

Employee Signature _____ Date _____

Please complete and sign both pages in their entirety if applying for medical coverage.

Health+

Employee Name:

G. Health Questions-Only Applies To New Groups Through First Year of Enrollment

❑Yes ❑ No In the last year, has anyone received medical treatment apart from routine physicals or inoculations? (If yes, list in section below.)
❑Yes ❑ No Do you or your dependent(s) take any medicine, drugs, pills or require shots? (If yes, list in section below.)
❑ Yes ❑ No Do you or your dependent(s) have treatments, tests, hospitalization or surgery planned in the future? (If yes, list in section below.)
❑Yes ❑ No Is anyone applying for coverage currently pregnant? Estimated due date ___/___/_____
❑Yes ❑ No Is anyone applying for coverage currently a tobacco user? (If yes, please list applicant name below.)

The following health questions pertain to your health coverage only and will be used to assess your employer health coverage risk. If you, or any person named in this application, has been diagnosed or treated in the last 10 years for any of the conditions listed below, please put an "X" in the box, and explain in Section H below.

- ❑ Arthritis
- ❑ Rheumatoid Arthritis
- ❑ Osteoarthritis
- ❑ Back/Spinal Disorder
- ❑ Back strain/Sprain
- ❑ Scoliosis
- ❑ Spinal Bifida
- ❑ Stroke
- ❑ Cancer, Leukemia, Melanoma
- ❑ Emphysema
- ❑ Chronic Bronchitis
- ❑ Asthma
- ❑ Other Lung Disorder
- ❑ Liver Disorder
- ❑ Congenital Disease/Defect
- ❑ Paralysis
- ❑ Multiple Sclerosis
- ❑ Cerebral Palsy
- ❑ Epilepsy
- ❑ Parkinson's
- ❑ Alzheimer's Disease
- ❑ Other Neurological Disease
- ❑ Hemophilia
- ❑ Kidney/Urinary Disorder
- ❑ Tumor/Growths
- ❑ Juvenile Diabetes
- ❑ Diabetes Mellitus
- ❑ Heart Attack/M.L.
- ❑ Coronary Artery Disease
- ❑ Bypass Surgery
- ❑ Congestive Heart Failure
- ❑ Pacemaker
- ❑ Ischemic Heart Disease
- ❑ Other Heart Disorders
- ❑ High Blood Pressure
- ❑ Alcohol or Drug Dependency
- ❑ Attempted Suicide
- ❑ Anorexia/Bulimia
- ❑ Chronic Depression
- ❑ Other Mental/Behavioral Disorder
- ❑ Venereal Disease/STD
- ❑ Deafness
- ❑ Ulcerative Colitis
- ❑ Diverticulitis
- ❑ Past Transplant or Current Transplant Waiting List
- ❑ Crohn's Disease
- ❑ Gastric/Peptic Ulcer
- ❑ Other Bowel/Stomach Disorder
- ❑ Premature Birth

IDENTIFY ANY OTHER CONDITIONS

- ❑ Other _____
- ❑ Other _____
- ❑ Other _____
- ❑ Other _____

List any other condition, treated in the last 10 years, not mentioned above:

H. Health Statement (If you checked any of the health questions or listed any other conditions on this form, please complete this section. Use additional pages if needed and include your signature and date.)

Name of Person	Condition	Date Diagnosed	Dates Treated	Type of Treatment/ Names of Medications	Are Medications Ongoing?	Is Treatment Ongoing?

I. Authorization and Certification

I have read and understand the Authorization and Certification language below and acknowledge receipt of a fully completed copy of this application.

Employee Signature Date / /

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I understand that I am making application for the coverage sponsored by my employer or group sponsor offered by NFA Health+ Incorporated Cell (NFAH+ IC). I authorize my employer, as my agent, to deduct from my pay or collect from me in advance the monthly rates therefore and remit such sums to the Plans on my behalf. This authorization is to remain in effect until the Plans are notified by me or my employer to the contrary. I understand that written notice of rate changes will be furnished by my employer as my agent. I further understand that the coverage's applied for will not start until after this application and the appropriate coverage rates are received and accepted by each Plan and an effective date of coverage is established by the Plans. I certify that, after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that the Plans will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, the Plans will be entitled to declare the contracts applied for void and to refuse allowance on benefits to any person there under.

I authorize any health care provider, including but not limited to; surgeon, physician, psychologist, nurse, social worker, or health care facility to release to the Plans all health & mental records, including those records protected by Federal or State law relating to AIDS or AIDS related complex, mental health and substance abuse, the past, present, or future treatments or conditions for myself or for my dependents eligible for health care coverage. This information is being used to carry out pre-enrollment underwriting and is in force until that process is complete, at which time it expires. I understand that I have the right to revoke this authorization in writing at any time by delivering such written notification to the requestor. I understand that a revocation is not effective until received by the requestor. I further understand that any revocation is not effective to the extent that the Plans or Provider have relied on it in the use or disclosure of protected health information. This form does not authorize the re-disclosure of medical information. Federal and State regulations do not allow further disclosure of mental health, substance abuse and AIDS/HIV related information. NFAH+ IC maintains the confidentiality of all information received and it will not be released to any person or facility unless the individual is applying for coverage underwritten by NFA Health+ Incorporated Cell (NFAH+ IC) in which case the application, without any further health records or Attending Physician Statements (APS) received, will be released to NFA Health+ Incorporated Cell (NFAH+ IC). The protected health information described above may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws. I understand that I have the right to refuse to sign this authorization, but that the Plans then have the right to condition eligibility determination and enrollment on the receipt of this signed authorization