



EMPLOYEE MEDICAL EVIDENCE OF INSURABILITY & APPLICATION



CALIFORNIA ONLY

Application to American Alternative Insurance Corp. Princeton, NJ
May be Photocopied or Duplicated for use. Please complete in ink and initial any alterations.

SECTION 1 – APPLICANT INFORMATION

| | | | | | |
|--|--------------------------------------|---|-------|--|--|
| FULL NAME OF EMPLOYEE | | MARITAL OR DOMESTIC PARTNERSHIP STATUS | | ADM. Use Only | |
| RESIDENCE ADDRESS | | CITY | STATE | ZIP | |
| TELEPHONE NUMBER (include area code) | | Best time to contact (if additional information is required by Insurance Company) | | | |
| DATE BEGAN FULL TIME (mm/dd/yy) | | SOCIAL SECURITY NUMBER | | | |
| EMPLOYED BY | EMPLOYER'S PHONE (include area code) | AVG. NO. HOURS WORKED WEEKLY | | MONTHLY EARNINGS | |
| EMPLOYER'S LOCATION – STREET ADDRESS | | CITY | STATE | ZIP | |
| OCCUPATION AND DUTIES | | LIFE INSURANCE BENEFICIARY AND RELATIONSHIP | | | |
| <input type="checkbox"/> I AM <input type="checkbox"/> I AM NOT AN OWNER, PARTNER OR CORPORATE OFFICER OF THE ABOVE EMPLOYER | | | | | |
| I Am Applying for (check one): <input type="checkbox"/> SELF ONLY <input type="checkbox"/> SELF AND SPOUSE OR DOMESTIC PARTNER <input type="checkbox"/> SELF AND CHILD(REN) <input type="checkbox"/> SELF, SPOUSE OR DOMESTIC PARTNER, AND CHILD(REN) | | | | | |
| I Am Applying for (check all that apply): <input type="checkbox"/> HEALTH INSURANCE <input type="checkbox"/> LIFE INSURANCE | | | | | |
| | | | | CASE NO. | |
| | | | | EMPLOYEE NO. | |
| | | | | CLASS | |
| | | | | EFFECTIVE DATE | |
| | | | | OCC YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | UWF 48 YES <input type="checkbox"/> NO <input type="checkbox"/> DATE _____ | |
| | | | | UWF 40 YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | HEALTH YES <input type="checkbox"/> NO <input type="checkbox"/> LIFE YES <input type="checkbox"/> NO <input type="checkbox"/> | |

If you have dependents (spouse or domestic partner and/or children) and have chosen not to include any dependents in this coverage, please complete the following:
 I AM NOT APPLYING FOR DEPENDENT COVERAGE FOR SPOUSE OR DOMESTIC PARTNER CHILDREN BECAUSE (check one):
 Covered by another group/individual health plan. Other (explain) _____
 I understand that, if I have dependents and do not make application at this time, I may be forfeiting certain rights as described on the reverse under Applicant Statement. I understand that I have the right to apply for dependent coverage at this time. I am voluntarily declining dependent coverage and have not been induced or pressured by anyone to decline coverage.

| PARTICIPANT INFORMATION | | | | | | | ADM. USE ONLY | | | | |
|---|--------------|-----|--------|--------|---------------|------------------------|---------------|-----|-----|-----|-----|
| Complete for each person to be insured. (use additional sheet if necessary) | | | | | | | | | | | |
| NAMES OF PARTICIPANTS | RELATIONSHIP | SEX | HEIGHT | WEIGHT | DATE OF BIRTH | SOCIAL SECURITY NUMBER | MUW | MHX | LAT | D&R | PXT |
| 1. Employee Name | Self | | | | | | | | | | |
| 2. | | | | | | | | | | | |
| 3. | | | | | | | | | | | |
| 4. | | | | | | | | | | | |
| 5. | | | | | | | | | | | |
| 6. | | | | | | | | | | | |

SECTION 2 – PRIOR INSURANCE COVERAGE CREDIT

Have you or your dependents been covered under any health insurance plan within the last 180 days (excluding any Waiting Period)? .. YES NO
If Yes, to qualify for prior coverage credit, please provide the following information on all coverage inforce in the past 12 months – Please note that most of this information can be obtained from your current Insurance Identification Card:

Name of Insurance Company _____ Ins. Co. Phone Number () _____

Effective date of Prior Coverage* _____ Termination Date _____

Reason for Coverage Termination _____

Type of Coverage (i.e., employer sponsored or individual) _____ Policy/Cert. Number _____

Coverage was for (check all that apply): Self Spouse or Domestic Partner Children

**We need confirmation of your coverage with your prior carrier. Please provide us with a copy of the Certificate of Creditable coverage provided by the carrier.*

SECTION 3 – MEDICAL INFORMATION Please give details to any “Yes” answer below.

1. Within the last five (5) years, have you or any dependent to be insured been hospital confined for any reason? YES NO
2. Within the last twelve (12) months, have you or any dependent to be insured been advised by any medical professional to have any medical treatment, diagnostic testing or surgery that has not been completed? YES NO
3. Are you or any dependent (whether applying for coverage or not) currently pregnant or receiving fertility treatments or, if insuring dependents, are you an expectant father or in the process of adopting? YES NO
4. Is anyone applying for coverage disabled, or restricted in or unable to perform the normal activities of daily living and self care? YES NO
5. Is anyone currently taking any prescription medication? YES NO
6. Within the last five (5) years, have you or any dependent to be insured, seen, been recommended to see or been treated by any medical professional, or been diagnosed with or received diagnostic testing, medication or abnormal test results, for any of the following conditions? Please circle all that apply and provide details below

- ◆ Brain or Nervous System
- ◆ Heart or Circulatory System
- ◆ Blood Disorder
- ◆ Liver, Pancreas or Kidney Disorder
- ◆ Diabetes or Sugar in Urine
- ◆ Multiple Sclerosis or Cerebral Palsy
- ◆ Organ or Tissue Transplant
- ◆ Lupus
- ◆ Abnormal Blood Pressure
- ◆ Chest Pain or Stroke
- ◆ Cirrhosis or Hepatitis C
- ◆ Pituitary Disorder
- ◆ Chronic Obstructive Pulmonary Disease Cystic Fibrosis, Pulmonary Embolism or Tuberculosis
- ◆ Cancer, Leukemia, Hodgkin’s Disease or Tumor (excluding basal cell)
- ◆ Immune Disorders including AIDS, HIV and ARC
- ◆ Substance Abuse, Nervous, Mental or Emotional Disorders not including general anxiety disorders or panic attacks

Use this space to give details to any “YES” answer to questions 1 through 6. Use a separate sheet if additional space is needed; sign & attach additional pages.

| Person | Medical Condition or Specific Reason for Treatment | Dates of Treatment | Medications & Dosages | Recovery Status | Please list any treatment, surgery or anticipated surgery for this condition. |
|--------|--|--------------------|-----------------------|-----------------|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

SECTION 4 – APPLICANT STATEMENT AND SIGNATURE

I hereby apply for insurance to which I am now or may become entitled under the provisions of the Master Policy issued by the Insurance Company. I authorize my employer to pay premiums and to deduct any required premium contribution from my earnings. I understand that my employer is being authorized to pay premium, is my agent and not the agent of the Insurance Company, and that my insurance may be terminated if premiums are not paid by my employer as required.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be found guilty of insurance fraud in a court of law. I understand that my coverage, if approved, and that of my eligible dependents, will be subject to the pre-existing condition and replacement of coverage provisions specified in the Master Policy. I understand that, subject to the replacement of coverage provisions of the Master Policy, I may not be eligible for coverage if I am currently totally disabled.

If I choose not to apply for dependent coverage and my dependents do not currently have other qualifying coverage, I understand that my dependents' right to enroll in the future may be restricted: 1) For medical insurance, their Pre-Existing Condition Limitation Period will be extended to twelve (12) months; 2) For life insurance, satisfactory evidence of their insurability will be required at my expense. Refer to the Late Applicant Eligibility, Effective Dates and Pre-Existing Conditions Limitations provisions set forth in the Master Policy. As a result, I also waive all claims under the Master Policy to such forfeited benefits for my dependents.

PERSONAL INFORMATION NOTICE

As required by law, this notice is intended to inform you that 1) Personal information may be collected from persons other than the individual applying for coverage; 2) Such information as well as other personal or privileged information collected by the Insurance Company or its legal representative may be in certain instances, as prescribed by law, disclosed to third parties without your prior authorization; 3) You have the right to access and correct the collected information; 4) Your right to access does not include any information which relates to and is collected in connection with, or in reasonable anticipation of, a claim or civil or criminal proceeding; 5) We will provide a more detailed notice of insurance information practices upon request.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the disclosure of all nonpublic personal information and individually identifiable protected health information for me (and my dependent(s), if requesting dependent coverage), including but not limited to employment status, other insurance coverage, diagnosis, prognosis, medical treatment or care and physical or mental conditions (including alcohol or drug dependency), by any physician, medical practitioner, hospital, other medical related facility, insurance company, employer or benefit plan having such information, to the Insurance Company or its legal representative, agent or vendor, for the purpose of approving enrollment and processing claims. I acknowledge and agree that this authorization shall be valid for two (2) years; that I may revoke it in writing at any time; that I may request a copy of this authorization; that enrollment, but not the processing of claims, is conditioned on my signing this authorization; that this authorization will be used as its own document, separate from the application; that a photocopy of this authorization shall be as valid as the original; and that I have authority to act as the personal representative of my dependent(s) (if requesting dependent coverage).

Signature of Employee X _____ Date _____

RETURN APPLICATION TO ALLIED NATIONAL, INC. • DBA ALLIED ADMINISTRATION & INSURANCE SERVICES UNDERWRITING • P.O. BOX 29187 • SHAWNEE MISSION, KS 66201-9187

Electronic copies of this application submitted via facsimile, email, or other electronic means shall be deemed an original.

AGENT STATEMENT

To the best of my knowledge, the information on the application is complete and accurate. I have explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

Notice: If a declarant willfully states as true any material fact he or she knows to be false, that person shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars (\$10,000). Any public prosecutor may bring a civil action to impose that civil penalty. These penalties shall be paid to the Insurance Fund.

Signature of Agent (required)

Date

Print Name

CALIFORNIA LANGUAGE SURVEY

In order to provide Language Assistance Services to our health plan insureds in the state of California, we are required to ask you to complete this survey to self-identify your race, ethnicity and language preferences. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information obtained will be kept confidential and may only be used in accordance with the provisions of applicable laws and regulations.

What is your race? _____

If the race of any member of your household covered by the health plan is different than yours please state their race:

What is your ethnic background? _____

If the ethnic background of any member of your household covered by the health plan is different than yours please state their ethnic background:

Are you fluent in speaking English? If not, what language is your primary spoken language?

If the primary spoken language of any member of your household covered by the health plan is different than yours please indicate what language that is:

Are you fluent in written English? If not, what language is your primary written language?

If the primary written language of any member of your household covered by the health plan is different than yours please indicate what language that is:

No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or 1-800-825-7531. For more help call the CA Dept. of Insurance at 1-800-927-4357.
English

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-800-825-7531. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم Arabic. 1-800-927-4357

Անվճար Լեզվական Օգնություններ: Դուք կարող եք թարգման և կարգադրել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-800-825-7531 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Գալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

免費語言服務。 您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-800-825-7531 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。 Chinese

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-800-825-7531. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357. Hmong

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または 1-800-825-7531 までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。 Japanese

សេវាកម្មភាសាឥតគិតថ្លៃ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអាសវកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមាន បង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-800-825-7531 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357. Khmer

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-800-825-7531 번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

خدمات مجاني مربوط به زبان . میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگورید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسایی شما قید شده است و یا این شماره 1-800-825-7531 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਬਾਰੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਤੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-800-825-7531 'ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੇਲੀਫੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ ਇਨਸੂਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫੋਨ ਕਰੋ। Punjabi

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-800-825-7531. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-800-825-7531. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-800-825-7531. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Tagalog

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-800-825-7531. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese.