

Waiver (Please complete if you are waiving medical or dental coverage.)

I waive medical coverage for: <input type="checkbox"/> Self (and dependents) <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents	Please state reason for waiving coverage: _____
I waive dental coverage for: <input type="checkbox"/> Self (and dependents) <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents	Qualifying Coverage _____ Other _____

If I have waived coverage for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in the policy, provided that I request enrollment within 31 days after my other coverage ends because of involuntary loss of other coverage (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll my dependents, provided that I request enrollment within 31 days after the date of the event. I further understand that if I am considered a late enrollee, I may be declined from coverage, excluded from coverage for a period of time, or subject to pre-existing limitations as defined in and where permitted by law, and I may be required to provide, where allowed by law, Medical History satisfactory to American Medical Security, Inc. or United Wisconsin Life Insurance Company, for myself and/or my dependents. I further understand that if this form is submitted after the enrollment period, and I am approved for coverage, a longer limitation may apply to pre-existing conditions disclosed herein.

Depending upon state law, this information may be submitted as evidence of insurability.

REQUIRED MEDICAL INFORMATION

1. Yes No Are you or any eligible dependent disabled, hospital confined, or pregnant?
2. Yes No In the last five years, have you or any eligible dependents incurred claims in excess of \$2,500?
3. Yes No Within the past five years, has any person to be insured been diagnosed or treated by a physician or member of the medical profession for acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?
4. Yes No Is any person to be insured receiving treatment, taking medication, or been advised of a condition that will require attention or routine follow-up in the next 24 months?
5. Yes No Within the past five years, has any person to be insured been diagnosed, had symptoms, had testing completed, had treatment, taken medications or had routine follow up for any of the following: Cancer/Tumor, Diabetes, Heart/Blood/ Vascular Disorder, Kidney Disorder, Liver Disorder, Neurological Disease, Respiratory/Lung Disorder, Stroke, Systemic Lupus/Multiple Sclerosis, Transplants, or Mental or Emotional Disorder?

Provide details to "YES" answers in the chart below. (If more space is needed, attach an additional sheet of paper, sign and date it.)

Note: For groups of 2-14 medical lives & underwritten add-ons/changes, completion of the Add'l Medical History section is needed to complete processing. If not applicable, continue on with Prior Medical/Dental Coverage section.

ADD'L MEDICAL HISTORY

1. Have you or any eligible dependent ever been declined, postponed, ridered, or rated up for medical, disability, or life insurance with another insurance carrier? Yes No
2. Within the past five years, has any person to be insured ever had any symptoms, diagnosis, consultation, treatment, or taken any medication or received counseling for...

A. Alcohol/Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	G. Digestive/Eating Disorder..... <input type="checkbox"/> Yes <input type="checkbox"/> No	M. Muscle Disorder/Neurological Disease... <input type="checkbox"/> Yes <input type="checkbox"/> No
B. Arthritis/Back/Joint Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	H. Ear/Eye Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	N. Skin Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
C. Asthma/Tobacco Usage..... <input type="checkbox"/> Yes <input type="checkbox"/> No	I. Epilepsy/Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	O. Thyroid/Adrenal Disorder..... <input type="checkbox"/> Yes <input type="checkbox"/> No
D. Blood Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	J. Genital/Urinary Disorder..... <input type="checkbox"/> Yes <input type="checkbox"/> No	P. Tuberculosis/Hepatitis A, B, or C..... <input type="checkbox"/> Yes <input type="checkbox"/> No
E. Breast Disorder or Breast Implants.. <input type="checkbox"/> Yes <input type="checkbox"/> No	K. High Blood Pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Q. Sleep Apnea <input type="checkbox"/> Yes <input type="checkbox"/> No
F. Congenital Disorder or Deformity... <input type="checkbox"/> Yes <input type="checkbox"/> No	L. Infertility..... <input type="checkbox"/> Yes <input type="checkbox"/> No	R. Systemic Infection..... <input type="checkbox"/> Yes <input type="checkbox"/> No

Provide details to "YES" answers in the chart below. (If more space is needed, attach an additional sheet of paper, sign and date it.)

Question/Letter	Name	Illness/Impairment	Dates Treated	Medications/Treatment/Surgery/Treating Physician

Prior Medical/Dental Coverage Information

Medical: If you are enrolling in a medical plan that is subject to Federal and/or state insurance small group reform laws, you may be eligible for a pre-existing condition limitation credit. Failure to provide the following information may result in a delay of benefits. Please attach any Certificate(s) of Creditable Coverage or other similar proof of coverage you have received.

Yes No Have you or any dependents applying for coverage been covered by this employer's prior group medical plan?

Yes No Have you or any dependents applying for coverage been covered by any medical plan other than this employer's prior group plan? If yes:

Insurance Company Name _____ Phone # _____ Policy/Group # _____

Termination Date _____ Effective Date _____ Reason for Termination _____

Who was covered? _____

Type of Plan: Prior Employer Group Plan Spouses Employer Group Plan Individual Policy Other _____

Dental: If you are enrolling on a timely basis after the effective date of this employer's dental plan, you may be eligible for credit toward plan waiting periods. Failure to provide the following information may result in a delay of benefits.

Insurance Company Name _____ Phone # _____ Policy/Group # _____

Termination Date _____ Effective Date _____ Reason for Termination _____

Who was covered? _____ Did plan include orthodontia benefits? Yes No

SIGNATURE REQUIRED – EMPLOYEE AGREEMENT

I understand that the above answers will be relied upon by United Wisconsin Life Insurance Company (the "Insurer") in the issuance of a certificate of insurance. I declare all statements contained in this entire form are true and correct and that no material information has been withheld or omitted. I understand and agree that the Insurer is not bound by any statement made by or to any agent unless written herein. I agree that no insurance will be effective until the date specified by the Insurer in the certificate of insurance. If I am now waiving medical and/or dental coverage for myself and/or for my dependents, I have read the entire Waiver provision, and understand the enrollment requirements if I make request for such coverage at a later date.

To assist American Medical Security, Inc. (AMS) with determining my creditable coverage, I authorize any insurance company, third party administrator or other authorized carrier, to release to AMS, third party administrator for Insurer, certificates of creditable coverage and all such information.

I authorize my employer to deduct the necessary contribution toward the premium. I reserve the right to revoke this deduction authorization at any time upon my written notice. This application will be part of the contract. Coverage is effective only after approval by the Insurer or AMS and satisfaction of any probationary period.

In some states, any person who, knowingly and with intent to defraud an insurance company, submits an application or files a claim containing any materially false information may be guilty of insurance fraud, which is a crime. Unless all pages are attached and completed, this will not be considered as a complete application. **Information on the application is valid for a maximum of 60 days from the date of signature.**

- I also hereby acknowledge receipt of the "Protecting Your Privacy" and "Protecting Your Health Information" notices. I understand that I may request an additional copy of these notices at any time.

Applicant Signature X _____ Date (required) _____

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant.

Spouse Signature X _____ Date (required) _____
(If spouse is to be insured)

SIGNATURE REQUIRED/AUTHORIZATION TO USE MEDICAL INFORMATION FOR ENROLLMENT

Please clearly print all information.

I hereby authorize those physicians, medical practitioners, hospitals, clinics, veterans administration facilities, medical information services, urgent care facilities, and other medical or medically related entities, insurance or reinsurance companies, and consumer reporting agencies that have information available as to the present or former physical health condition, including drug or alcohol or domestic abuse, and/or treatment of me or my dependents to release any and all such information, including, but not limited to, medical records, health-care provider notes, laboratory tests and results, diagnoses, treatment, and prognoses. I understand the information obtained by use of this authorization may be used to determine eligibility for issuance of health coverage and eligibility for benefits under an existing policy/certificate of insurance for me and my dependents. This authorization is not applicable to psychotherapy notes.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall expire 30 months after the termination of any coverage I obtain. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. Because this authorization is given as a condition of obtaining insurance coverage, my revocation will not prevent the Insurer from the right to contest a claim under the policy if another law so allows. Should me or my dependents refuse to sign this authorization, I understand it may affect my enrollment in the benefit plan. All pages must be attached and complete, including this authorization for the application to be considered complete. Incomplete applications may be rejected.

Customer Signature X _____ Date _____

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant.

Spouse Signature X _____ Date _____
(If spouse is covered)

Signature of Each Covered Dependent Age 18 and Over:

X _____ Date _____ X _____ Date _____

X _____ Date _____ X _____ Date _____

Designed, Administered, and Marketed by:



P.O. Box 19032, Green Bay, WI 54307-9032
(920) 661-1111 • (800) 232-5432

Insurance Products

Underwritten by:



P.O. Box 19032, Green Bay, WI 54307-9032
(920) 661-6020