Medical Application

Before beginning, please ensure you have the names of your medications and dosage information immediately available.

CORNERSTONE PREFERRED RESOURCES

Employer **Effective Date**

Social Security Number **Last Name** **First Name** **MI** **Phone**

Street Address **City** **State** **Zip** **County**

Email Address **Married** **Sex** **Birth Date**

☐ Yes ☐ No ☐ M ☐ F

Job Title **Date Employed** **Date of Marriage**

What plan have you chosen: Plan Name

Are you actively at work? ☐ Yes ☐ No **Are you working 30 hrs or more per week (avg)?** ☐ Yes ☐ No

Relation to Employee	Last Name	First Name	Social Security Number	Height	Weight	DOB	Sex M/F
Self							
Spouse							
Dependent Child							
Dependent Child							
Dependent Child							

Do you or your dependents have other medical coverage? ☐ Yes ☐ No **(If Yes, please indicate;** ☐ Self ☐ Spouse ☐ Children

Name of Insured **Social Security Number** **Name of other insurance Company** **Group No.**

Employer of Insured **Employer Address** **City** **State** **Zip**

To the best of my knowledge, I believe the above information is true and correct. I understand that false or inaccurate information may result in the termination of coverage or the non-payment of benefits.

Please type your name here **Date Signed**

Waiver of Insurance Coverage

Rejection of Health Coverage. After careful consideration, I do not wish to participate in any of the available plans. I also realize I will NOT be able to re-enroll until next open enrollment period and then I may be required to provide Medical Proof of Insurability.

Please type your name here **Date Signed**

Person	Please check the box for each family member that is choosing medical coverage
Employee	☐ **Yes** ☐ **No**
Spouse	☐ **Yes** ☐ **No**
Children	☐ **Yes** ☐ **No**

HEALTH STATEMENT-Please complete for only those persons electing coverage. Misstatements & omissions made by you on this form may cause you to lose coverage under your employer's plan.

You may be asked to call a medical underwriter to answer questions about any health information you are providing and/or missing on this form. This interview may be recorded for quality assurance.

Daytime Phone Number _____

1. Within the **past 5 years**, have you, your spouse, or dependent children been tested, diagnosed, or treated **(including the use of medication)**, been advised to seek treatment, or has any further treatment been recommended for:	
A. Arthritis, Bone, Joint, Spine, Musculoskeletal Disorders, Muscle or Connective Tissue Disorder	☐ **Yes** ☐ **No**
B. Bone Marrow or Organ Transplants	☐ **Yes** ☐ **No**
C. Cancer, Tumor, Polyp or Leukemia and/or Hodgkins Lymphoma	☐ **Yes** ☐ **No**
D. Cirrhosis, Hepatitis or other diseases of the Liver	☐ **Yes** ☐ **No**
E. Collagen Disease including Lupus	☐ **Yes** ☐ **No**
F. Digestive System Disorder, including Diseases of the Colon, Gallbladder, Pancreas, Stomach, Esophagus or Intestines	☐ **Yes** ☐ **No**
G. Diabetes, Thyroid Disorder or Disease of the Endocrine System	☐ **Yes** ☐ **No**
H. Drug Abuse, Alcohol Abuse, Fetal Alcohol Syndrome or Psychiatric Disorder	☐ **Yes** ☐ **No**
I. Eyes, Ears, Nose, Throat Disorder, or Meningitis	☐ **Yes** ☐ **No**
J. Growth or Developmental Disorder	☐ **Yes** ☐ **No**
K. Heart, Circulatory Disorder, Blood Disorder (including High Blood Pressure), Edema or Hemophilia	☐ **Yes** ☐ **No**
L. Immune System Disorder, including AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)	☐ **Yes** ☐ **No**
M. Metabolic and Nutritional Disorders (including Hypercholesterolemia)	☐ **Yes** ☐ **No**
N. Quadriplegia, Paraplegia, Hemiplegia or Congenital Disorder	☐ **Yes** ☐ **No**
O. Neurological Disorder, including Alzheimer's Disease, Brain Disorders, Cerebal Palsy, Epilepsy, Migraines, Parkinson's Disease, Seizures or Multiple Sclerosis	☐ **Yes** ☐ **No**
P. Reproductive System Disorder including Infertility Treatment	☐ **Yes** ☐ **No**
Q. Respiratory Disorder or Sleep Disorder	☐ **Yes** ☐ **No**
R. Rheumatic Fever or Cystic Fibrosis	☐ **Yes** ☐ **No**
S. Urologic Disorders or Renal Disorders (including Renal Failure)	☐ **Yes** ☐ **No**
T. Vascular Disorders including stroke, CVA (Cerebro Vascular Accident) or TIA (Transient Ischemic Attack)	☐ **Yes** ☐ **No**
2. Do you, your spouse, or dependent children have any condition that may require diagnostic testing, medical, surgical, or hospital care, or any condition, illness, or injury for which a physician has not yet been consulted?	☐ **Yes** ☐ **No**
3. Are you or any of your dependents currently pregnant or in the process of adopting a child? **If "Yes", provide the due/adoption date on the next page and describe any complications experienced or if multiple births are expected.)**	☐ **Yes** ☐ **No**
4. Are you or any of your dependents currently disabled?	☐ **Yes** ☐ **No**
5. Have you or any of your dependents been hospitalized for any treatment or procedure within the past 12 months?	☐ **Yes** ☐ **No**

Details from health statement above

Please fully complete the following information

Question Number & Letter	First Name, Last Name	Diagnosis & Details about Conditions above *(Please list Medications, Dosage and Frequency)*	Date of onset	Date of Full Recovery	Doctors Name & Phone Number

REPRESENTATION & AUTHORIZATION - Please read this section carefully then sign & date the form below

SPECIAL ENROLLMENT NOTICE

If you decline medical and/or dental coverage for yourself, your spouse, or your dependents at this time for any reason, you may later be eligible to enroll yourself, your spouse and/or your newly acquired dependent(s) in medical and/or dental coverage within 30 days of acquiring the dependent(s) through marriage, birth, adoption, or placement for adoption. If you decline medical and/or dental coverage for yourself or your dependents at this time because of coverage under other health insurance coverage, you or your dependents may later be eligible to apply for medical and/or dental coverage without penalty within 30 days after you or you dependents' other health coverage ends, but only if you state in STEP 4 that other health coverage is the reason for declining coverage. The penalty for failure to state that other health coverage was the reason for declining this coverage will be a 6-month waiting period under this plan after you apply for coverage hereunder.

I represent: (1) I am an employee of the participating employer and the persons for whom I am requesting coverage are US Citizens or Legal Aliens residing in the USA; (2) the statements and answers to the questions on this Enrollment/Refusal Form made by me are true and complete to the best of my knowledge; (3) I understand that the statements and answers to questions on this Enrollment/Refusal Form made by me and any subsequent information I provide are the basis for my coverage under my employers' plan and coverage will not be effective until I am notified of my effective date; (4) is made arising out of or relating to a claim for benefits payable by the self-funded plan it shall be settled by arbitration in accordance with the provisions of the plan.

I hereby authorize those physicians, medical practitioners, hospital, clinics, pharmacies, pharmacy benefit managers, veteran's 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 Cornerstone Preferred Resources 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 existing health coverage 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 be valid for 2 ½ years from the date shown below. 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. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. Because this authorization is given as a condition of obtaining coverage, my revocation will not prevent the Insurer and/or Plan Sponsor from the right to contest a claim if another law so allows. Should I 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.

"This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law."

Fraud Notice: Any person who knowingly and with intent to defraud or deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties.

Has any person assisted you in the completion of this form? ☐ **Yes** ☐ **No** **If Yes, Print Name:**

Employee Signature

Date Signed