APPLICATION/ENROLLMENT FORM

NIPPON LIFE INSURANCE COMPANY OF AMERICA

Des Moines, IA 50309

Enrollment Instruction:

Please read carefully and provide complete information as requested on this Employee Enrollment Form. It is extremely important that any present and/or past medical history relating to you, your spouse, and/or your other dependents be accurately and completely explained. The "Waiver of Group Coverage" section on the reverse side must be completed in order to waive coverage. Please print legibly.

CHECK ONE			FOR OFFICE USE ONLY		
☐ New Enrollee	☐ Adding Dependents	☐ Other	Eff. Date	Group #	Plan

CURRENT STATUS					
☐ Currently working	☐ COBRA	☐ Continuation	☐ Disability	☐ Retired	☐ Other Leave _____

EMPLOYEE DATA					
Employee's Name (First, Middle, Last)	Marital Status	Occupation(Be specific)		Date Employed (Full-time)	Hours Worked Per Week
Address	Apt. No.	City	State	Zipcode	County
Home Phone ( )	Work Phone ( )	Employer's Name	Dept.		Annual Salary

COVERAGE SELECTION AND ENROLLMENT

I am selecting coverage for: ☐ Employee ☐ Employee and Spouse ☐ Employee and Children ☐ Employee, Spouse and Child(ren)

Please complete all information on self and family, whether applying for coverage or not

Name (First MI Last)	Relationship	Date of Birth	Social Security Number	Sex	Height	Weight	Other Coverage	Student
	Employee						Yes No	
	Spouse						Yes No	
	Child						Yes No	Yes No
	Child						Yes No	Yes No

List additional children on a separate sheet and staple to this form.

MEDICAL INFORMATION

Employee must answer the following questions on self and dependents, whether applying for coverage or not:	YES	NO
1. Within the past 5 years, have you or any dependent had or been treated for heart disorder(s), high blood pressure, stroke, cancer, tumor, diabetes, kidney or liver disease, an immune deficiency disorder, AIDS, AIDS-Related Complex (ARC), respiratory disorder(s), or any mental or nervous disorder?	☐	☐
2. Have you or any dependent ever had an application for insurance declined, postponed, rated or otherwise modified?	☐	☐
3. Have you or any dependent, within the last 12 months, incurred more than $5,000 in medical expense?	☐	☐
4. Are you or any family member currently pregnant? If "Yes", give approximate due date: _____	☐	☐
5. Within the past 5 years, have you or any dependent had or been treated for any of the following:		
a. arthritis, back bone or joint disorder?	☐	☐
b. seizures, convulsions, fainting spells or epilepsy?	☐	☐
c. digestive system disorder, ulcer, liver, colon or rectal disorder?	☐	☐
6. Within the past 3 years, have you or any dependent:		
a. been confined to a hospital or similar institution?	☐	☐
b. consulted or been treated by a physician, psychiatrist, psychologist, or other practitioner?	☐	☐
c. taken any medication?	☐	☐
d. had any symptoms not previously indicated?	☐	☐
7. Have you or any dependent ever used marijuana, cocaine, heroin or any other drugs not prescribed by a physician?	☐	☐

Details to "Yes" answers from questions 1-7, above

Question Number	Family Member	Nature of illness or injury (If operation performed, state type)	Date of Onset	Date last Seen by Dr.	Still under Doctor's care
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. The Health Insurance Portability & Accountability Act of 1996 (H.R. 3103) provides for federal penalties of up to 5 years imprisonment for intentional misrepresentation of information in any application for healthcare benefits.

OTHER INSUR ANCE

Have you or any of your dependents been insured through any other plan of health insurance within the past 18 consecutive months? ☐ Yes ☐ No
Please complete: Name of Insurance Company _____ Phone No. (____)_____
Employee Effective Date: _____ Employee Termination Date: _____ Policy or Certificate Number: _____
Dependent Effective Date: _____ Dependent Termination Date: _____
Type of Coverage: ☐ Employer Sponsored ☐ Individual Coverage was for: ☐ Self ☐ Spouse ☐ Child(ren)
Reason for loss of coverage: _____
(Attach the most recent billing and a copy of the outline of benefits.) (Attach copy of Certificate of Credible Coverage)
COMPLETED BY: ☐ Employee ☐ Employer

Beneficiary for Life and AD&D _____ Relationship _____

I hereby apply for insurance to which I am now or may become entitled under the provisions of the Group Insurance issued by the Insurance Company. I authorize my employer to deduct the required premium contribution, if any, from my earnings. I understand that my application for any non medical coverage is subject to approval by the Insurance Company. I understand that my medical coverage, and that of my dependents, if any, will be subject to the pre-existing condition provision specified in the Certificate, and that this provision has been fully explained to me.

I am applying for coverage under the Insurance Company's Precertification conditions. I authorize any physician, medical practitioner, hospital, clinic, or medical-related facility or insurance company having information available as to diagnosis, treatment and prognosis regarding any physical, mental, drug, or alcohol condition and/or any treatment of myself or my insured dependents t give/allow the Insurance Company or their legal representatives any and all such information including but not limited to Precertification of outpatient procedure or service and hospital admission, Continued Stay Review, On-Site concurrent Review and patient visitation while I or my insured dependents are or have been a patient of a physician, hospital, clinic or medical-related facility. I understand that failure to precertify results in reduced or no benefits.

Any information obtained will not be released by the Insurance Company to any person or organization except to persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize. I understand that this information obtained by the Insurance Company will be used to determine appropriate and accurate medical charges.

I hereby declare that the foregoing statements and answers made by me on behalf of myself and my dependents, if applying, are complete and true, and that they are correctly and fully recorded, and that no material circumstance or information has been intentionally withheld or omitted concerning myself and my dependents, if any, past and present state of health, and I agree that the answers and statements herein shall form a part of the certificate. I understand that any misstatements or failure to report information may be used as the basis of rescission of Insurance for myself or my dependents, if any. I also understand that insurance will not be in force until the application is approved by the Insurance Company.

Furthermore, I hereby authorize any physician or practitioner, hospital, or other organization, institution, or person that has any medical records or knowledge of me or my family to give to the Insurance Company or its Authorized Administration such information (photocopy of this authorization shall be valid as the original).

_____ _____
Date Signature of employee (and parent of applicant if under age 18)

WAIVER OF COVERAGE

(Please complete both Sections)

Section 1:
☐ I waive medical coverage for myself (and dependents, if any)
☐ I waive medical coverage for my spouse
☐ I waive medical coverage for my children

Section 2:
Reason for declining coverage (check one)
☐ Covered by spouse's group coverage
☐ Covered by H.M.O.
☐ Other (explain) _____

This is to acknowledge that the available coverage have been explained to me by my employer. I have been given opportunity to apply for the available coverage and have elected not to enroll myself and/or my dependents, if any. I understand that I may have to provide medical evidence at my own expense if I desire to apply for such non medical insurance at some later date for myself and/pr my dependents if applying for them.

_____ _____ _____
Date Name of Employee (type or Print) Signature of Employee (In ink)

Please mail all materials to: TOTAL PLAN SERVICES, INC. 14001 Dallas Parkway North, Suite 700 Dallas, TX 75240