



GROUP EMPLOYEE ENROLLMENT/CHANGE FORM

Select One:  New  Change
(Please Type Or Print In Ink.)



1. Employer Information

Name of Employer Date of Hire Requested Effective Date

2. Employee Information

Last Name First Name MI Social Security# Date of Birth

Mailing Address

City, State Zip Code Phone (h) Phone (w)

Are you (the employee) currently working? Hours worked per week Date of Marriage:

COBRA Expiration Date: Medical Plan Option Selected

3. Waiver of Coverage

I decline to enroll in health coverage for:
If declining coverage, please complete a separate Waiver of Group Coverage form.

4. Purpose of Application

Type of Membership Requested:
You are (Select best answer):

5. Family Information

Table with columns: Full Name of ALL MEMBERS to be Covered, Social Security #, Sex (M/F), Date of Birth, Height, Weight, HMO Members: Primary Care Physician (PCP)

Do any of the dependents listed above live at an address DIFFERENT than the employee, including full time students?

6. Other Health Insurance Information

Have you or anyone listed on this application received benefits or compensation for an occupational injury, accident, illness or disease?

Are you or any of your dependents disabled? Medicare Reason Part A (Hosp) Effective Date: Part B (Med) Effective Date:

Have you or anyone listed on this application had health coverage within the last 63 days? Company Name Phone Address Group/Policy Number Name of Insured Dependents Covered Effective Date of Coverage Date Certificate of Coverage Issued

**Name of Employee:** \_\_\_\_\_

**7. Medical History (Mark Yes or No to every question for ALL family members to be covered.)**

1. Within the lifetime of any person applying for coverage, has any person applying for coverage ever had any reason to know of, or consulted with a provider of health care services for medical advice, diagnosis, care or treatment for any of the following:	Enrollee		Spouse/Dependent		Children	
	Yes	No	Yes	No	Yes	No
A. Diabetes (Type 1 or 2), hypoglycemia, or any glandular disorder, including but not limited to, thyroid (hypothyroid, hyperthyroid, etc) or recurrent enlarged glands?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Rheumatic fever, abnormal blood pressure, high cholesterol levels, or any heart disorder, including but not limited to heart attack, angina pectoris, stroke, palpitations, chest pain, irregular pulse, heart murmur, or valve prolapse? Blood Pressure Readings If Applicable (Give three most recent readings): Name: _____ Date & Reading _____  Last Cholesterol Readings: Name: _____ Date & Reading _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Any disease of the stomach, gall bladder or liver, including but not limited to ulcers, gallstones, jaundice, colitis, diverticulitis, diverticulosis, bleeding from the intestinal tract, Crohn's disease, or other disorder of the gastrointestinal system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. A mental disease or emotional disorder, including, but not limited to depression, anxiety, schizophrenia, attention deficit disorder, attention deficit disorder with hyperactivity or any other form of mental disease, condition or illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. A disease of the brain or nervous system, including but not limited to epilepsy, convulsion, multiple sclerosis (MS) or Parkinson's disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Any form of cancer (local, regional or distant) including but not limited to carcinoma, lymphoma, sarcoma, melanoma, or leukemia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Any injury or disease of the back or spine, or disorder of the muscles, bones or joints, including but not limited to arthritis, spondylitis, spondylolisthesis or muscular dystrophy? H.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Lupus, autoimmune disease or disorder, Epstein-Barr, chronic fatigue or fibromyalgia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has any person applying for coverage tested positive for HIV or its antibodies, or been diagnosed or treated by a provider of health care services for Acquired Immune Deficiency (AIDS) or AIDS related complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**For each "Yes" answer to question 1 (A-I), complete the following (attach separate sheet if necessary):**

Name of Person	Condition	Treatment Dates		Hospitalized?	Treatment and/or Future Treatments
		From	To		

**Name of Employee:** \_\_\_\_\_

<b>2. Do you now take, or in the last 5 years have you taken any prescription drugs?</b>	<b>Enrollee</b>		<b>Spouse/Dependent</b>		<b>Children</b>	
	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**For each "Yes" answer to question 2, complete the following (attach separate sheet if necessary):**

Name of Person Taking Medication	Name of Medication	Dates Medication Taken		Dosage & How often refilled	For What Condition(s)
		From	To		

<b>3. In the last 10 years (unless otherwise stated), has any person applying for coverage consulted with or received medical advice or treatment by a physician or medical practitioner for any of the following?</b>	<b>Enrollee</b>		<b>Spouse/Dependent</b>		<b>Children</b>	
	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
A. Any disease of the female organs, including but not limited to fibroid uterus, endometriosis, cysts, dysmenorrhea (difficult/painful menstruation), menometrorrhagia (irregular and/or excessive bleeding during and between menses), abnormal pap smear or biopsy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Any disease of the male organs, including but not limited to undescended testicles, hydrocele, epididymitis, or disease of the prostate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Any disease of the breasts, including but not limited to fibrocystic breast disease or any diagnostic testing or treatment related to the breast, e.g. needle biopsy, excision biopsy, ultrasound or mammogram?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Any diagnostic testing and or treatment related to the reproductive tract or the process of conception?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Any sexually transmitted disease? (Specify type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Any disease of the lungs or respiratory system, including but not limited to asthma, tuberculosis or emphysema?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Any other illness, disease or injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Alcohol or controlled substances abuse? If Drug, What Form.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**For each "Yes" answer to question 3 (A-J), complete the following (attach separate sheet if necessary):**

Name of Person	Condition	Treatment Dates		Hospitalized?	Treatment and/or Future Treatments
		From	To		

<b>4. In the last 5 years (unless otherwise stated), has any person applying for coverage consulted with or received medical advice or treatment by a physician or medical practitioner for any of the following?</b>	<b>Enrollee</b>		<b>Spouse/Dependent</b>		<b>Children</b>	
	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
A. Polyp, cyst or tumor? (Where located)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Any disorder of the blood or blood vessels, including but not limited to varicose veins or anemia (what form)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Any skin disorder, including but not limited to acne, psoriasis, or eczema?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Any disorder of the eyes, ears, nose or throat, including but not limited to speech impairment, loss of sight or loss of hearing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Any disorder of the prostate, bladder, kidneys or any treatment related to the urinary tract, including but not limited to, kidney stones, nephritis, cystitis, pus in urine or renal colic?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Name of Employee:** \_\_\_\_\_

F. Any significant weight loss or weight gain, shortness of breath, chest pain or irregular pulse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Any type of hernia? (Specify type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Appendicitis or persistent diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Fainting or loss of consciousness, severe headaches, migraine headaches or constant nervousness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Any allergies, pleurisy, hay fever, persistent hoarseness, chronic cough or bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Symptoms of any type of disease, sickness or health impairment not mentioned above, or any other causes for which you have been treated, hospitalized or consulted a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Do you now use tobacco or have you used tobacco in the last four years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**For each "Yes" answer to question 4 (A-L), complete the following (attach separate sheet if necessary):**

Name of Person	Condition	Treatment Dates		Hospitalized?	Treatment and/or Future Treatments
		From	To		

	Enrollee		Spouse/Dependent		Children	
	Yes	No	Yes	No	Yes	No
<b>5. Are you or any of your dependents now pregnant? Explain any signs of complications or past complications:</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>6. Is any person not named on this Application now pregnant by any person to be insured?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>7. Have you ever applied to, or been insured by this company? If so, please provide the name of the person you were insured under (if other than yourself).</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**8. Enrollment Agreement**

I (We), the Applicant (spouse and child(ren) over age 18), understand and agree that:

- This is an enrollment form only. No rights to coverage are conferred to any of the persons applying for coverage until New West accepts my (our) enrollment form and premiums.
- New West relies upon the information I (we) provided on this enrollment form and, if applicable, Medical History form.
- Premiums for the coverage must be paid on time in accordance with the payment option the employer selected. The employer's failure to pay any premium when due will result in cancellation of the coverage as of the last day of the month for which my (our) last premium was paid.
- I (We) agree to repay any benefit payments to which I (we) was (were) not entitled.
- From time to time, New West may need to obtain my (our) medical records. I (We) agree to cooperate with New West to obtain the information it needs to review my (our) claims.

I (We) certify that each person applying agrees to the terms and conditions of any contract issued by New West. I (we) personally completed the enrollment form and, if applicable, Medical History form. I(We) certify that all of the information provided in this enrollment form or other information provided to New West by me (us) are true, complete and correct. I (We) have received the New West Notice of Privacy Practices. I (We) hereby apply for coverage with New West and agree that the coverage for which I (we) am (are) applying for is subject to eligibility requirements. The actual effective date of coverage will be assigned by New West. I (We) have read, understand and agree to the terms set forth above.

**9. Signature**

<b>Employee Signature</b>	<b>Date Signed</b>	<b>Spouse/Dependent Signature (if applicable)</b>	<b>Date Signed</b>
<b>Dependent Over Age 18</b>	<b>Date Signed</b>	<b>Dependent Over Age 18</b>	<b>Date Signed</b>