HOW TO COMPLETE THE ENCLOSED ENROLLMENT/ DECLINATION FORM

The enclosed "EDIS" form is used if you choose to enroll or decline the group health insurance plan. It must be completed and returned to So Cal Corporate by the date stated in the letter.

If you choose to decline:

1. Complete the top portion of page 1 "enrollee information"
2. Complete the middle section of page 1 "waiver"
3. Sign page 2- "Employee Agreement" and "Signature Required"

If you choose to enroll:

1. Page 1- Please complete all the below listed section
    a. Enrollee Information – very important to complete all portion (height and weight included)
    b. Eligibility & other insurance information- please complete
    c. Coverage & Change request information- please complete
2. Page 2- Please complete all below listed sections
    a. Family information – Must complete the entire section for anyone individuals who are enrolling on the plan with you. Skip if you are not enrolling anyone else besides yourself.
    b. Required Medical Information- Please answer Y or N to all questions!
        i. If you answer Y to any of the questions you must give the details in the section provided at the bottom of the required medical information section.
    c. Sign and date both signatures lines on page 2

See instruction sheet. Must complete if declining or enrolling.
This is a manadatory form that is due back by_______

EMPLOYEE ENROLLMENT FORM

Level-Funded Medical Coverage

Employer Name:________________________	Employer Location (if more than one) ________________________

ENROLLEE INFORMATION

Last Name:	First Name:	Initial:	Gender: ☐ M ☐ F ☐ Single Height:________ ☐ Married Weight:________
Address:	City:	State:	Zip:
County:	Home Phone #: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___	Enrollee Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___	
Date of Birth: ___ / ___ / ______ Date Employed Full Time: ___ / ___ / ______	Occupation: Are you an independent contractor? ☐ Y ☐ N	Annual Salary: $	Average Hours Worked Per Week:

ANCILLARY PLAN OPTIONS (If offered by your employer):

Freedom Dental™

☐ Fully Insured Freedom Dental™ Plan Selection: ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 Network: PPO or EPO (select one)
Network Vendor: First Dental Health (Default) or Other: ________________

☐ Pre-Paid DHMO / Western Dental®

☐ 100% Self-Funded Dental (must complete the Employer Elect Application)

Eagle Vision™

☐ 100% Self-Funded Vision Plan

WAIVER
(Please complete if you are declining medical coverage)

Check all of the following that apply: I waive medical coverage for: ☐ Employee ☐ Spouse ☐ Child(ren) I waive dental coverage for: ☐ Employee ☐ Spouse ☐ Child(ren) I waive vision coverage for: ☐ Employee ☐ Spouse ☐ Child(ren)	Reason for waiving coverage:________________________ 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 coverage, 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 or excluded from coverage for a period of time as defined in and where permitted by law, and I may be required to provide, where allowed by law, Medical History satisfactory to the Plan Sponsor or Administrator, for myself and/or my dependents.

ELIGIBILITY & OTHER INSURANCE INFORMATION

Currently, are you working full-time? ☐ Y ☐ N If no, explain: ________________________	Do you or any family members intend to keep other insurance coverage in addition to this coverage? ☐ Y ☐ N If yes, list family members: ________________________
List the name of the other insurance company(ies) and the policy number(s):________________	List family members covered by Medicare and their effective date:________________

COVERAGE & CHANGE REQUEST INFORMATION

Coverage Level: ☐ Employee ☐ Family ☐ Employee/Spouse ☐ Employee/Child(ren)	Name of medical plan you have selected:________________ PPO Network Name:

Change Request: ☐ Marriage ☐ Divorce ☐ Adoption ☐ Returning to school full-time ☐ Court Order

Date of Event (you may be required to provide proof of the event): _____/______/_____

**Attach a written and signed statement by the employer for a requested coverage effective date. Effective date may not be guaranteed.

FAMILY INFORMATION

(Only for those applying for coverage)

First Name & M. I. (last name if different)	Gender	Date of Birth	Height	Weight	Social Security No.	Primary Care Physician's Name
Spouse:	☐ M ☐ F	/ /			/ /	
Child:	☐ M ☐ F	/ /			/ /	
Child:	☐ M ☐ F	/ /			/ /	
Child:	☐ M ☐ F	/ /			/ /	

REQUIRED MEDICAL INFORMATION

1. ☐ Y ☐ N Are you or any dependent disabled, hospital confined, or pregnant? If pregnant, due date: ____/____/____
   If pregnant, are you expecting a multiple birth / having complications / planning a C-Section? ☐ Y ☐ N
2. ☐ Y ☐ N Have you or any eligible dependent used tobacco products in the past twelve (12) months?
3. ☐ Y ☐ N Are you or any eligible dependent receiving treatment; taking medication; receiving follow up care; scheduled for or awaiting results of any tests, biopsies, procedures or lab work; been advised to have a test; or been advised of a condition that will require attention in the next twenty-four (24) months?
4. ☐ Y ☐ N In the past five (5) years, have you or any eligible dependent to be insured had any symptoms, diagnosis, consultation, testing, treatment, follow up care, or taken any medication or received counseling for any of the following:

a ☐ Yes ☐ No Diabetes
b ☐ Yes ☐ No Kidney Disorder
c ☐ Yes ☐ No Infertility
d ☐ Yes ☐ No Neurological Disorder
e ☐ Yes ☐ No Arthritis/Back/Joint Disorder
f ☐ Yes ☐ No Cancer/Tumor
g ☐ Yes ☐ No Liver Disorder/Hepatitis
h ☐ Yes ☐ No Systemic Lupus/Multiple Sclerosis
i ☐ Yes ☐ No Intestinal / Digestive Disorder
j ☐ Yes ☐ No Mental Disorder Alcohol/Drug Abuse
k ☐ Yes ☐ No Heart/Blood/Vascular/Hypertension
l ☐ Yes ☐ No Birth Defects/Congenital Disorder
m ☐ Yes ☐ No Stroke
n ☐ Yes ☐ No Organ/Tissue Transplants
o ☐ Yes ☐ No Respiratory/Lung Disorder
p ☐ Yes ☐ No Immune System Disorder
q ☐ Yes ☐ No Acquired Immune Deficiency Syndrome(AIDS) / AIDS Related Complex (ARC)/HIV

Please provide details to "Yes" answers, including information regarding last doctor visit and/or physical examination and all medications taken (attach extra pages if needed with signature and date.)

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

EMPLOYEE AGREEMENT – SIGNATURE REQUIRED

***To be a valid enrollment, your signature and the date you sign it are required.**

I understand that the previous answers will be relied upon by the Plan Sponsor in the issuance of a Summary Plan Description. I declare all statements contained in this entire form about me and my dependents are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand that my intentional misrepresentation of a material fact or my failure to report information about me or my dependents may be used as the basis to rescind, terminate or modify coverage for me or my dependents. Rescind means that the coverage was never in effect. I understand and agree that the Plan Sponsor is not bound by any statement made by or to any agent unless written herein. I agree that no coverage will be effective until the date specified by the Plan Sponsor in the Summary Plan Description. The actual effective date may not be the requested effective date. If I am now waiving medical benefits for myself and/or my dependents, I have read the entire Waiver provision, and understand the enrollment requirements if I make request for such benefits at a later date. I authorize my employer to deduct the necessary contribution toward the benefits. I reserve the right to revoke this deduction authorization at any time upon my written notice. Benefits are effective only after approval by the Plan Sponsor or Administrator and satisfaction of any probationary period. To assist with determining my creditable coverage, I authorize any insurance company, third party administrator, or other carrier or provider of health benefits to release to the third party administrator and/or Plan Sponsor certificates of creditable coverage and all such information. Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false information may be found guilty of fraud, which is a crime, in a court of law and may be subject to fines and confinement in prison. This will not be considered as a complete application unless all pages are attached and completed.

☐ I understand that information on this application is valid for a maximum of 90 days from the date of signature.

Enrollee Signature X ______________________________ Date (required) ______________ If signed by a representative of enrollee, please indicate the representative's authority to act on behalf of enrollee.______________________________

SIGNATURE REQUIRED / AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR ENROLLMENT

I hereby authorize those physicians, medical practitioners, hospital, clinics, veteran's administration facilities, medical information services, urgent care facilities, pharmacy, pharmacy benefit manager, health plan, 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 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 further understand the information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. 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 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.

Enrollee Signature X ______________________________ Date (required) ______________ If signed by a representative of enrollee, please indicate the representative's authority to act on behalf of enrollee.______________________________